HEALTH PROGRAM

HEALTH SYSTEM STRENGTHENING COMPONENT

Financed by USAID and implemented by Abt Associates in collaboration with Group ISSA, CRDH, ACA, PATH, FHI and Broad Branch

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ANNUAL REPORT – October 2012 to September 2013

Training of CHW and matrons in the health district of Kolda on Performance-Based Financing

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Abbreviations and Acronyms

ACA	Association Conseil pour l'Action
AIDS	Acquired Immuno-Deficiency Syndrome
AWP	Annual Work Plan
ARD	*Agence Régionale de Développement* / Regional Development Agency
BAP	*Bureau d'Appui au Projet FBR* / PBF Project Support Bureau
BTC	Belgian Technical Cooperation
CACMU	*Cellule d'Appui à la Couverture Maladie Universelle* / Support bureau for Universal Health Coverage
CBO	Community-Based Organization
CDD	*Comité Départemental de Développement* / Departmental Committee for Development
CDS	*Comité départemental de suivi* / Departmental Monitoring Committee
CHW	Community Health Worker
CONSAS	*Concertations Nationales sur la Santé et l'Action Sociale* / National consultations on healthcare and social action
COP	Chief of Party
CRDH	Centre de Recherche pour le Développement Humain
CRS	*Comité régional de suivi* / Regional monitoring committee
CTGP	*Comité Technique de Gestion du Projet* / Project Management Technical Committee
DAGE	*Direction de l'Administration Générale et de l'Equipement* / Directorate of General Administration and Equipment
DF	Direct financing
DHMT	District Health Management Team
DLSI	*Division de la Lutte contre le SIDA* / Division of AIDS Control
DMO	Chief District Medical Officer
DPRS	Department of Planning, Research and Statistics
DSRSE	*Direction de la Santé de Reproduction et de la Santé de l'Enfant* / Department of Reproductive Health and Child Health
EIPS	*Equipe d'Initiative de Politiques de Santé* / Health Policy Initiatives Group
FHI	Family Health International
FNSS	*Fonds National de la Solidarité dans la Santé* / National Solidarity Fund for Healthcare
FY	Fiscal Year
H2S	Health System Strengthening Component
ICP	*Infirmier Chef de Poste* / Chief nursing officer at health post
ISSA	Innovations et Systèmes de Santé en Afrique
JPR	Joint Portfolio Review
MEF	Ministry of Economy and Finance
MIS	Management Information System
MHO	Mutual Health Organization
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health and Social Action
MTEF	Medium Term Expenditure Framework
NGO	Non-Governmental Organization
ONAMS	*Office national de la mutualité sociale* / National office on social insurance
ORCAP	*Outil de Renforcement des Capacités par l'Auto-évaluation Participatives* / Capacity development tool through self-assessment
PBF	Performance-Based Financing
PLWHA	Person Living With HIV/AIDS
PNA	*Pharmacie Nationale d'Approvisionnement* / National medical store

PNDS	*Programme National de Développement Sanitaire* / National Health Development Program
RH	Reproductive Health
RHMT	Regional Health Management Team
RMO	Chief Regional Medical Officer
SDP	Service Delivery Point
TFP	Technical and Financial Partner
UEMOA	*Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

The Health System Strengthening (H2S) Component is one of USAID/Senegal's assistance instruments under its 2011-2016 Health Program. It is based on the strategic directions set out in the National Health Development Plan (PNDS) for 2009-2018. The main objective of the Component is to improve the performance of the decentralized (regional and district levels) public health system supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health and Social Action (MOH). The Component is expected to contribute significantly to the achievement of Intermediate Result 3 of the Health Program's results framework: "Improved performance of the health system". This will be realized through "an improved management of district and regional health teams" (Intermediate Result 3.1) and an "improved health system performance through development and implementation of national level policies" (Intermediate Result 3.2). The H2S Component works at the central level and in ten regions (Diourbel, Fatick, Kaffrine, Kaolack, Kolda, Louga, Sédhiou, Thiès, Ziguinchor, the departments of Pikine and Rufisque in the Dakar region).

USAID/Senegal signed a *cooperative agreement* with Abt Associates Inc. to serve as the implementing agency of the H2S Component: contract nr. AID-685-A-11-00002 (2011-2016). Abt Associates put up a multi-disciplinary team of Senegalese experts, Senegalese organizations and international sub-contractors to implement the H2S Component. In addition to Abt Associates Inc., the H2S team comprises Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA), Association Conseil pour l'Action (ACA), Centre de Recherche pour le Développement Humain (CRDH), Family Health International (FHI360), PATH and Broad Branch Associates.

The action plan for Year 2 (October 2012-September 2013) of the Health System Strengthening Component (H2S) was developed with the aim of seizing opportunities offered by the changing environment in the health sector. Focus is placed on the practical application of planning, management and financing instruments jointly developed by all Health Program components during Year 1 to improve health system performance. This not only facilitated progress at the operational level to improve the management of health district and regional teams, but progress was also achieved in policy development at the central level.

Intermediate Result 3.1 (IR3.1): Improved management of district and regional health teams.

The H2S Component advanced towards attaining IR3.1 of the USAID/Senegal results framework through accomplishments made during Year 2 for the improvement of health system governance at the local level, strengthening of capacities in planning, management and monitoring of health interventions, and implementation of new direct financing and performance-based financing instruments to enhance the performances of health service managers and health workers at health centers and health posts.

Health governance. To help improve health governance by actors who fully play their roles at the regional and health district levels, 297 members of regional health management and district health management teams in the 10 intervention regions were trained during Year 2 on health governance. Furthermore, consultation frameworks on healthcare are now functional in three intervention regions (Kaffrine, Kaolack and Thiès). Good governance indicators were measured in 834 healthcare service delivery points in intervention regions to help identify and address gaps in health governance at the local level.

Capacities in planning, management and monitoring of healthcare interventions. Several accomplishments were made during Year 2 in the effort to strengthen capacities of medical regions and health districts in planning, management and monitoring of healthcare interventions.

About one hundred (100) DHMT/RHMT members in the Kaolack, Louga and Thiès regions were trained on ORCAP for enhanced analysis in the Annual Work Plan (AWP) development process. Moreover, support was provided for AWP development and implementation monitoring in the ten (10) focus regions and their health districts. Also, training sessions on management were extended to all ten regions during Year 2: 86 RHMT/DHMT members in the 10 regions received training on accounting and financial management; 59 RHMT/DHMT members in the 3 direct financing regions received training on fixed assets accounting. Finally, support was provided for the conduct of annual joint portfolio reviews in all focus regions.

Direct financing initiative. The direct financing initiative was effectively launched in the pilot regions of Kaolack, Kolda and Thiès with a view to contributing to the adaptation of USAID's assistance delivery methods to the regional and local levels in the health sector with the collaboration of all Health Program components. Based on AWPs of health districts and medical regions in these three regions, RHMTs, cooperating agencies and regional bureaus of the Health Program identified, in a participatory manner, milestones to be reached by each target region as well as the related indicators. The planning and negotiation process led to the signing of three implementation letters with the three pilot regions and the effective payment of the first milestone to the three (3) pilot regions by all components.

Performance-based financing. The Performance-Based Financing (PBF) initiative was strengthened in the pilot regions to enhance coverage and quality of priority healthcare services (maternal health, family planning, child health, combating malaria, tuberculosis and HIV). The PBF verification system was consolidated during Year 2 with the organization of three (3) joint audit missions and household surveys. The first annual PBF review was held after the first test year in the pilot districts of Kaffrine and Kolda. Based on the recommendations of this first annual review, the PBF initiative was extended to all seven (7) health districts in the Kaffrine and Kolda regions. This extension was accompanied by training sessions for stakeholders: 156 beneficiaries in newly-enrolled health districts were trained on PBF; 117 CHW and matrons of health huts received orientation on PBF. Furthermore, data collection at health posts and centers was conducted in the five (5) newly-enrolled health districts to establish benchmarks. A total of 115 performance contracts were hence signed in the 7 pilot districts within the Kaffrine and Kolda regions during Year 2.

Administrative systems and tools currently being developed, experiences being acquired and lessons being learned through these initiatives are in the process of strengthening capacities in the health sector for the implementation of performance-based management systems. The MOH, with the support of the H2S Component, has thus started the process of learning from experience with the launch of the National Performance-Based Financing Program and the development of a new World Bank-funded project to support PBF extension.

Intermediate Result 3.2 (IR 3.2): Improved health system performance through development and implementation of national level policies.

The H2S Component progressed towards achieving IR 3.2 of USAID/Senegal's results framework through accomplishments made in the following three sub-components: (i) Social financing mechanisms; (ii) health policies and reforms; and (iii) coordination of the USAID/Senegal Health Program.

Social financing mechanisms. The H2S component continued its support at the strategic level to improve access to healthcare services and financial protection of populations in the area of healthcare and foster policy dialogue as well as establish MHO networks at the operational level. At the strategic level, the Component provided the MOH with assistance to prepare the inter-ministerial council meeting on Universal Health Coverage (UHC) held in April 2013, develop a

five-year action plan for the introduction of basic UHC for people in the informal and rural sectors, and organize the official launch of the UHC program by the President of the Republic in September 2013. The Component provided support to develop technical capacity building tools for MHOs including a procedures manual for MHOs adapted to UEMOA regulations and MHO training manuals under the UHC context.

At the operational level, the Component established the DECAM project in the three pilot departments of Kaolack, Kolda and Louga. It helped create twenty two (22) new MHOs and restructure twenty six (26) existing MHOs in these demonstration departments. In addition to these accomplishments in the three demonstration departments, fifty four (54) existing MHOs, ten (10) regional federations and five (5) departmental federations received direct support from the Component. A total of 460 MHO administrators and managers were trained on administrative and financial management. Furthermore, the Component maintained its support to consolidate the PLWHA project in Kaolack and initiated discussions with key partners to extend the project to Ziguinchor and Kolda; the Component also increased support to other initiatives for the protection of vulnerable groups in its intervention zones. The number of MHO beneficiaries in the Component's intervention zone has increased from 263,343 in 2012 to 337,872 in 2013 of whom 31,876 are vulnerable persons currently receiving healthcare coverage through MHOs.

Policies and reforms. The H2S Component continues to help build capacities in the formulation and implementation of healthcare reform policies. Assistance provided by H2S was increased at the request of the MOH and USAID for the organization of the national consultations on health and social action successfully held in January 2013. Pursuant to recommendations of the national consultations, the Component intensified its support to the MOH for follow-up of key measures on UHC extension.

The H2S Component's contribution in the formulation and implementation of policies was strengthened in the priority areas of community health, family planning and medicines. The Component provided the MOH with assistance to develop a community health policy document in close collaboration with the Community Health Component. Furthermore, FP advocacy tools were revised and a schedule prepared for support to advocacy, awareness-raising and monitoring activities at the national and regional levels. Furthermore, with support from H2S, the national medical store (PNA) now has an updated procurement manual and PNA has begun formulation of a strategic development plan to address new challenges in the drug supply sector.

The H2S Component continued its support for resource allocation and PNDS implementation. In addition to assistance being provided to develop the health sector MTEF and the related performance report, the Component also extended its support to include the preparation of regional health sector MTEFs. The MOH opted for the gradual establishment of regional health sector MTEFs, and the three regions of Kolda, Thiès and Kaffrine were hence accompanied during this fiscal year by the H2S Component. The Component also provided DAGE/MOH with assistance to prepare its annual financial report for 2012 and collect financial data for 2013. The process of introducing the health sector MTEF is currently being reinforced with the implementation of public finance management reforms at the country level following adaptation to the related UEMOA directives. Implementation of these reforms will result in the Component adapting its assistance in monitoring PNDS implementation.

Coordination of the Health Program. Coordination of USAID Health Program interventions was enhanced with the development of the first integrated action plan of the Health Program as well as the direct financing procedures manual aimed at adapting USAID's assistance delivery methods to the regional and local levels. The integrated action plan is now the tool being used by the Health Program's Steering Committee to summarize the Program's commitments and

implementation of its activities. Furthermore, regional bureaus of the Health Program now rely on the integrated action plan to fully play their role, support the development process and monitoring of annual work plans of health districts and medical regions, and to inform local stakeholders on the various commitments of the USAID Health Program's five components.

Results achieved over the first two years of the Program clearly reveal the ground that still has to be covered to reach the objectives of the Program. The H2S Component's annual action plan for Year 3 also takes these results into consideration as well as the changing environment in the sector. Authorities have included governance and universal health coverage among the priority issues on their political agenda. Furthermore, central and regional services of the MOH are currently being reorganized. In order to fit its priorities to these changes, the MOH held national consultations on health and social action (CONSAS), which led to key recommendations and measures on health governance and universal health coverage. Key health coverage measures were discussed during an inter-ministerial council on UHC; furthermore, a UHC strategic plan was developed and resources earmarked to support its implementation. The Performance-Based Financing (PBF) initiative has made significant progress since the first national review and the lifting of the strike action to withhold information. The PBF initiative was extended to seven health districts in two regions and a World Bank project is being developed to extend PBF to four other regions as of 2014. Finally, USAID/Senegal is committed to implementing a package of reforms relating to the way it does business, including the *Implementation and Procurement Reform (IPR)* which introduces direct financing mechanisms at the central and regional levels with the support of the Health Program's implementing agencies.

The annual action plan for Year 3 will continue to set the stage for the H2S Component to effectively help improve health system performance by focusing on the practical application of planning, implementation, management and financing instruments developed during the first two years.

Based on these general guidelines, the following priorities defined by the USAID Health Team directed the development of the 2013-2014 action plan:

- Nutrition activities;
- Implementation of the family planning action plan;
- PBF implementation and coordination with the World Bank program;
- Supply chain management assistance;
- Results/impact demonstrated through support to family planning, maternal health and child health interventions;
- Support to ensure universal health coverage;
- Implementation of direct financing activities;
- Coordination of regional bureau activities and integrated work plans.

Introduction

The National Health Development Plan (PNDS 2009-2018) is implemented via the four programs of the MTEF for health: (i) MNCH, (ii) disease control, (iii) health system strengthening, and (iv) health system governance. Health system strengthening and health governance are the strategic blueprint of the Health System Strengthening (H2S) Component of the USAID/Senegal 2011-2016 Health Program. These two programs focus inter alia on: (i) Performance-Based Management, (ii) enhancing planning as well as administrative and financial management capacities in the sector, and (iii) reinforcing health insurance coverage by putting emphasis on vulnerable groups.

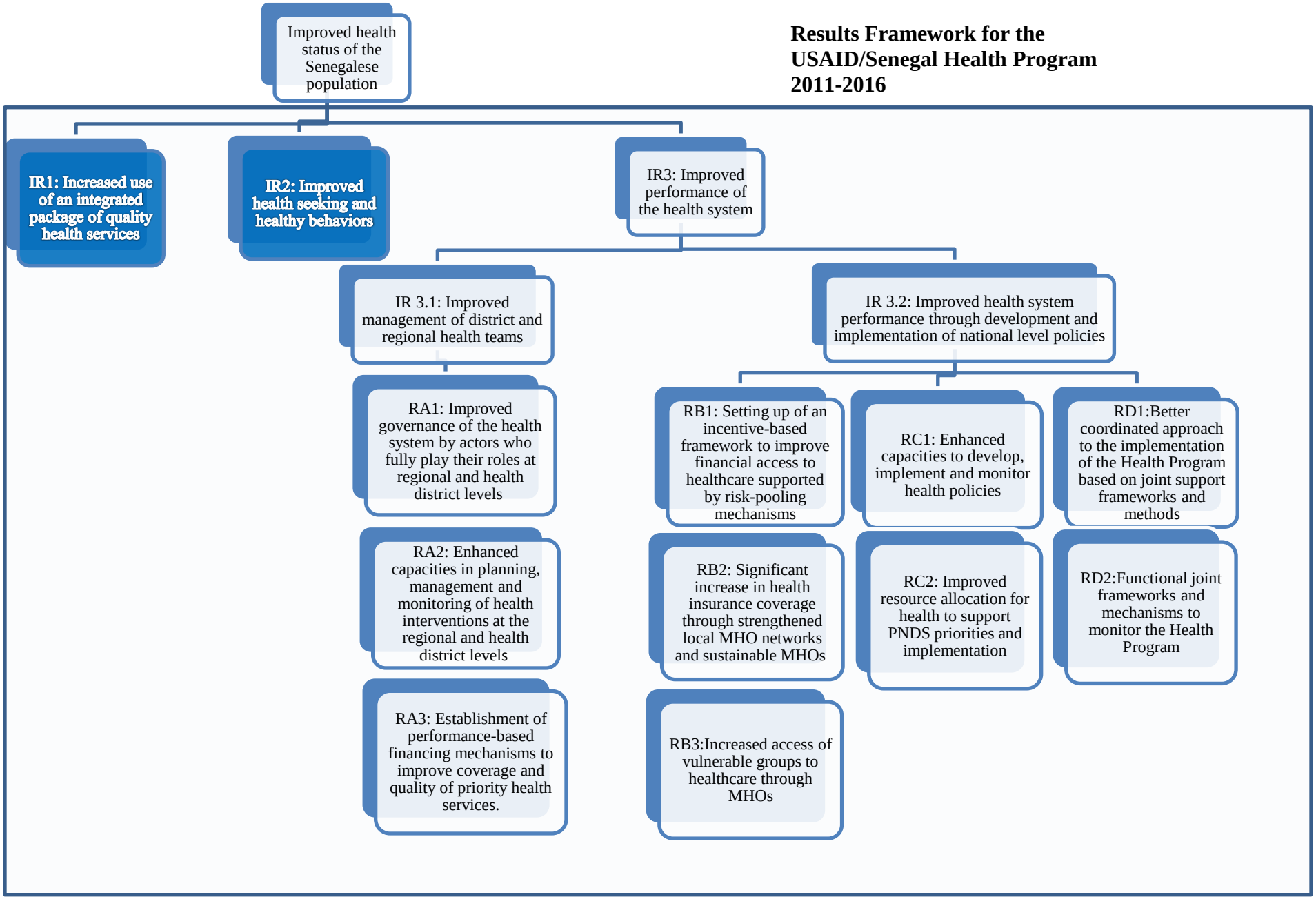
The H2S Component is one of USAID/Senegal's five assistance instruments under its 2011-2016 Health Program. The Development Objective of the Program is an "improved health status of the Senegalese population" and is to be reached through three intermediate results (IR): "Increased use of an integrated package of quality health services" (IR 1); "Improved health seeking and healthy behaviors" (IR 2); "Improved performance of the health system" (IR 3). The Health System Strengthening Component will contribute to achieving these intermediate results in collaboration with four other components of the USAID/Senegal Health Program: (i) health services improvement, (ii) HIV/AIDS and Tuberculosis, (iii) community health, and (iv) health communication and promotion.

The main objective of the H2S Component is to improve the performance of the decentralized (regional and district levels) public health system supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health. The H2S Component will contribute specifically to the realization of Intermediate Result 3 through "an improved management of district and regional health teams" (IR 3.1) and an "improved health system performance through development and implementation of national level policies" (IR 3.2).

USAID/Senegal signed a *cooperative agreement* with Abt Associates Inc., which has a long-standing reputation worldwide in health systems, health sector reforms and health financing reforms, to serve as the implementing agency of the H2S Component. Abt Associates put up a multi-disciplinary team of Senegalese experts, Senegalese organizations and international sub-contractors with long and valuable experience to implement the H2S Component. In addition to Abt Associates Inc., the Abt team comprises Groupe Innovations et Systèmes de Santé en Afrique (Group ISSA), Association Conseil pour l'Action (ACA), Centre de Recherche pour le Développement Humain (CRDH), Family Health International (FHI), PATH and Broad Branch Associates.

Interventions of the H2S Component will take into account accomplishments of the previous USAID Health Program, particularly those achieved by its "Healthcare Financing and Policy" component of which two activity areas were maintained: social financing through MHOs and health policy dialogue. In order to maintain focus on the Health Program's intermediate results over the next five years, the technical proposal for the H2S Component submitted to USAID by the Abt team included an indicative program with the following four sub-components: (i) Management and health systems at regional and district levels, (ii) Social financing mechanisms, (iii) Policies and reforms, and (iv) Coordination of the Health Program. **Figure 1** summarizes the contribution of the H2S Component to the Health Program's results framework through its sub-components and areas of action.

Results Framework for the USAID/Senegal Health Program 2011-2016



Expected results of the H2S Component are centered on key areas for improving performance of health systems. The "management and health systems at regional and district levels" sub-component will contribute to improving the effectiveness and quality of healthcare service delivery through improved health system governance at the local level, enhanced capacities of regional and health district management teams, motivation of staff working at health huts, posts and centers to extend the reach of priority healthcare services supported by performance-based financing mechanisms. The "social financing mechanisms" sub-component will focus on improving access to healthcare for populations in general and vulnerable groups in particular, by reducing financial barriers to healthcare and expanding health insurance coverage through mutual health insurance schemes and the support of government authorities. Finally, sustainable improvements in health system performance will be ensured with the creation of an enabling environment to support policy development, the enhancement of resource allocation for the sector, synergy and alignment of interventions with PNDS 2009-2018 priorities through the sub-components "Policies and reforms" and "Coordination of the Health Program".

The action plan for Year 2 (October 2012 – September 2013) of the Health System Strengthening Component takes into account priorities defined by the MOH and USAID as well as changes in the project environment associated with the arrival in 2012 of a new political regime and the implementation of reforms in the way USAID delivers its assistance. The annual action plan for Year 2 sets the stage for the H2S Component to seize opportunities provided by the changing environment to improve health system performance, focus on the practical application of planning, management and financing instruments jointly developed by all Health Program components during Year 1, and maintain flexibility to ensure action plan interventions are in line with results and recommendations of national consultations on health and social action (CONSAS). Based on these general guidelines, the following priorities directed the development of the 2012-2013 action plan:

- PBF extension to seven (7) health districts;
- Implementation of the Direct Financing pilot phase in three (3) regions;
- Extension of activities relating to the strengthening of management and monitoring capacities of medical regions and health districts;
- Consolidation of the social financing mechanisms strategic support framework;
- Consolidation of the project to expand health insurance coverage within a decentralization context (DECAM project) in focus departments;
- Development of the community health policy;
- Advocacy work to reposition family planning;
- Strengthening the capacities of the National Medical Store (PNA);
- Consolidation of the Health Policy Initiatives Group (EIPS) and the Medium Term Expenditure Framework (MTEF) for the health sector as part of on-going organizational reforms within the MOH;
- Strengthening synergies between Health program components.

The annual report is organized in four (4) sections. The first section summarizes accomplishments of the Component during the second year. The section analyzes problems encountered during activity implementation. The third section summarizes the financial implementation of the Component. The fourth section identifies key changes in the immediate environment of the Component, as well as guidelines and priorities for its third year. The annual report is supplemented by two attachments: Attachment 1 summarizes the Component's financial report and Attachment 2 presents the PMP indicators of the Component.

1. Achievements at the end of Year 2

The action plan for Year 2 (October 2012-September 2013) of the Health System Strengthening (H2S) Component was designed to seize opportunities provided by the changing environment to improve health system performance by focusing on the practical application of planning, management and financing instruments jointly developed by all Health Program components during Year 1. This not only facilitated progress at the operational level to improve the management of health district and regional teams, but progress was also achieved in policy development at the central level. This simultaneous progress at both operational and strategic levels was made possible by the systematic empowerment of MOH responsibility centers at the national, regional and local levels for the joint implementation of interventions supported by the H2S Component.

Progress made towards improving health system performance will, in this activity report, be presented in relation to the intermediate results of the USAID Health Program Results Framework. The first section 1.1 will therefore summarize the main achievements of the H2S Component and how they interact to contribute to the realization of intermediate results 3.1 and 3.2. Ensuing sections will provide further details on the main achievements while focusing on new initiatives and changes in the policy environment of the health sector. Section 1.2 will discuss enhancement of management systems at the medical region and health district levels while paying special attention to progress made under the direct financing and performance-based financing initiatives. Section 1.3 will focus on progress made in the social financing mechanisms area, laying emphasis on the DECAM initiative and changes in the health insurance policy environment. Section 1.4 summarizes progress made in the health policies and reform area as well as changes in public finance management and its implications for the health sector. Finally, Section 1.5 will cover progress made in coordinating the Health Program.

1.1. Progress towards enhanced health system performance

The H2S Component, supported by the implementation and consolidation of approaches and technical tools developed during Year 1, progressed towards improving health system performance through the enhanced management of health district and regional health management teams as well as implementation of national level policies. The following table summarizes progress made by the H2S Component at the end of Year 2 towards reaching the intermediate results of USAID/Senegal's Health Program Results Framework.

H2S results at the end of Year 2 in relation to the Intermediate Results of the USAID Results Framework	
IR 3.1: "Improved management of district and regional health teams"	**IR 3.2: "Improved health system performance through development and implementation of national level policies"**
Health governance • 297 RHMT/DHMT members in the 10 intervention regions trained on health governance • Functional consultative platforms in three (3) regions • Good governance indicators measured in 834 healthcare service delivery points ***Capacities in planning, management and monitoring*** • 100 RHMT/DHMT members in the Kaolack, Louga and Thiès regions trained on ORCAP • Support provided for AWP development and implementation monitoring in all ten (10) focus regions and their health districts • 86 RHMT/DHMT members in the 10 regions trained on accounting and financial management; 59 RHMT/DHMT members in the 3 direct financing districts trained on fixed assets accounting • Assistance for the organization of annual joint portfolio reviews in each of the ten (10) intervention regions • Implementation letters signed between contracting agencies and the three direct financing medical regions (Kaolack, Kolda and Thiès); payments to medical regions for first milestones effected. ***Performance-based financing (PBF)*** • Three (03) joint verification missions and household surveys conducted • Holding of the first national PBF review • PBF tools revised (procedures manual, quality checklist, PBF indicators…) • Baseline references gathered for the 5 new districts • 156 stakeholders trained on PBF • 117 CHW and matrons of health huts received orientation on PBF • 115 contracts signed in the 7 PBF pilot districts in the Kaffrine and Kolda regions • Payment of PBF bonuses in the Kaffrine and Kolda districts	***Social financing mechanisms*** • 337,872 MHO beneficiaries in intervention regions • 31,876 vulnerable persons covered by MHOs through third-party payers • Development of the action plan for basic UHC in the informal and rural sectors • Development of the MHO management procedures manual adapted to the UEMOA regulation; production of training of trainers' manuals • Establishment of 22 new MHOs and restructuring of 26 existing MHOs in demonstration departments (Kaolack, Kolda and Louga) • 460 MHO administrators and managers trained on administrative and financial management • Setting up of 3 departmental monitoring committees (CDS) and organization of 6 monitoring meetings in demonstration departments • Direct support to 54 MHOs in the other intervention zones (training, general assembly meetings, awareness-raising, planning workshop, etc…) • Direct support to 10 regional federations, 5 departmental federations (Diourbel, Bambey, Touba, Rufisque and Pikine) and 5 district federations • Consolidation of the PLWHA project in Kaolack and extension to Ziguinchor ***Policies and reforms*** • Community health policy paper developed and approved by the Steering Committee (in collaboration with Community Health Component) • PNA procurement manual developed, PRA staff trained • National consultations on healthcare and social action held • Kolda and Thiès regional health sector MTEFs validated and that of Kaffrine finalized; 2014-2016 preliminary health sector MTEF and 2012 performance report prepared • 2012 Financial report of DAGE produced ***Coordination*** • Operations manual of regional bureaus updated • Exchange of experiences between administrative and financial staff of regional bureaus and those of Components • 2013 annual action plan of the H2S Component and integrated action plan of Health Program approved • Meeting of Health Program Steering Committee for the first half of the year held on May 14, 2013 • Identification of common interest themes by Components

Intermediate Result 3.1 (IR3.1): Improved management of district and regional health teams.

The H2S Component progressed towards attaining IR 3.1 of the USAID/Senegal Results Framework with accomplishments made in the following areas: (i) health governance, (ii) capacities in planning, management and monitoring of healthcare interventions, (iii) direct financing, and (iv) performance-based financing.

Firstly, training of stakeholders on health governance was extended to include all ten focus regions so as to ensure improved health governance by stakeholder who fully play their roles at the regional and health district levels. Multi-sectoral consultation frameworks on health were made operational in the focus regions. These activities provided a platform to share and discuss good governance indicator levels with stakeholders and identify actions to be implemented for improved health governance at the local level.

Secondly, several accomplishments were made in the effort to strengthen capacities of medical regions and health districts in planning, managing and monitoring healthcare interventions. After the regions of Kolda, Sédhiou and Ziguinchor covered during Year 1, utilization of the ORCAP tool was extended to the three regions of Kaolack, Louga and Thiès during Year 2 to ensure improved analysis during the AWP development process. In collaboration with all Health Program Components, the H2S Component provided support for the development, implementation and monitoring of AWPs of health districts and medical regions in all ten focus regions. Furthermore, training sessions on accounting and financial management were extended to all ten regions and training on fixed assets management commenced in the three regions of Kaolack, Kolda and Thiès in Year 2. The H2S Component also provided support for the conduct of annual joint portfolio reviews in all focus regions.

Thirdly, the direct financing initiative was effectively launched in the pilot regions of Kaolack, Kolda and Thiès with a view to contributing to the adaptation of USAID's assistance delivery methods to the regional and local levels in the health sector with the collaboration of all Health Program components. Based on AWPs of health districts and medical regions in these three regions, the direct financing procedures manual jointly developed by all Health Program components and activities eligible for direct financing, RHMTs, cooperating agencies and regional bureaus of the Health Program identified, in a participatory manner, milestones to be reached by each target region as well as the related indicators. The planning and negotiation process led to the signing of three implementation letters with the three pilot regions and the effective payment of the first milestone to the three (3) pilot regions by all components.

Fourthly, the Performance-Based Financing (PBF) initiative was strengthened in the pilot regions to help establish performance-based financing mechanisms thereby enhancing coverage and quality of priority healthcare services (maternal health, family planning, child health, combating malaria, tuberculosis and HIV). The first annual PBF review was held after the first test year in the pilot districts of Kaffrine and Kolda. Based on the recommendations of this national review, the PBF initiative was extended to all seven (7) health districts in the Kaffrine and Kolda regions during this year. A total of 115 performance contracts were signed in 2013 with health posts, health centers and district health management teams in the two regions to enhance coverage and quality of priority healthcare services.

In sum, the improved management of district and regional health teams is supported by strong internal systems and incentive structures that will help create favorable conditions for the sustained enhancement of health system performance at various levels. Regarding service delivery and health

workers, PBF targeting of health posts, health centers and health district management teams is currently motivating frontline health workers to improve coverage and quality of priority healthcare services. As regards healthcare services management, strengthening the capacities of health district and regional health teams in planning, managing and monitoring healthcare interventions helps ensure they play their role of providing technical and operational support and coordinating interventions. The direct financing initiative was designed to contribute to the capacity-building and empowerment of district and regional health management teams.

Administrative systems and tools currently being developed, experiences being acquired and lessons being learned through these initiatives are in the process of strengthening capacities in the health sector for the implementation of performance-based management (PBM) systems and are also evidence of its effective functioning. PBM is at the core of the public finance management reform currently being implemented at the country level, and the MOH, with the support of the H2S Component, has thus started the process of learning from experience with the launch of the National Performance-Based Financing Program and the development of a new World Bank-funded project to support PBF extension.

Intermediate Result 3.2 (IR 3.2): Improved health system performance through development and implementation of national level policies.

The H2S Component progressed towards achieving IR 3.2 of USAID/Senegal's results framework through accomplishments made in the following three sub-components: (i) Social financing mechanisms, (ii) health policies and reforms, and (iii) coordination of the USAID/Senegal Health Program.

Firstly, the H2S component continued its support to MHO networks at the operational level to improve access to healthcare services and financial protection of populations in the informal and rural sectors. The Component established the DECAM project in the three pilot departments of Kaolack, Kolda and Louga. It helped create twenty two (22) new MHOs and restructure twenty six (26) existing MHOs in these focus departments. A departmental monitoring committee, chaired by the Préfet of the department, was put in place to ensure follow-up of DECAM activities in each department. In addition to these accomplishments in the three demonstration departments, the Component also pursued its support activities in its other intervention departments and regions. Thus, fifty four (54) existing MHOs, ten (10) regional MHO federations and five (5) departmental MHO federations continued to receive direct support from the Component.

Furthermore, the Component maintained its support to consolidate the PLWHA project in Kaolack and initiated discussions with key partners to extend the project to Ziguinchor and Kolda; the Component also increased support to other initiatives for the protection of vulnerable groups in its intervention zones. The number of MHO beneficiaries in the Component's intervention zone has increased from 263,343 in 2012 to 337,872 in 2013; 31,876 vulnerable persons are currently receiving healthcare coverage through MHOs in the Component's intervention regions.

In addition to providing operational support, the Component also helped develop technical capacity building tools for MHOs including a procedures manual for MHOs and MHO training manuals under the UHC context. Development of these technical tools is in response to the MOH's request to extend DECAM to fourteen (14) departments as of 2013/2014 based on the experiences of the three demonstration departments and major developments in the UHC policy this year.

Secondly, the H2S Component continues to help build capacities in the formulation and implementation of healthcare reform policies. Assistance provided by H2S was increased at the request of the MOH and USAID for the organization of the national consultations on health and social action successfully held in January 2013. Following the recommendations of the national consultations on health and social action, the Component assisted the MOH in the preparation of an inter-ministerial council on Universal Health Coverage (UHC) in April 2013 and the formulation of a five-year action plan to introduce basic UHC for people in the informal and rural sectors. In September 2013, the H2S Component assisted the MOH to organize the official launch of the UHC program by the President of the Republic.

The Component's contribution in the formulation and implementation of policies was strengthened in the priority areas of community health, family planning and medicines. The Component provided the MOH with assistance to develop a community health policy document in close collaboration with the Community Health Component implemented by the consortium of NGOs led by ChildFund. Furthermore, FP advocacy tools were revised and a schedule prepared for support to advocacy, awareness-raising and monitoring activities at the national and regional levels. Furthermore, with support from H2S, the national medical store (PNA) now has an updated procurement manual, its management and information system is currently being set up, and it has begun formulation of a strategic development plan to address new challenges in the drug supply sector.

The H2S Component continued its support for resource allocation and PNDS implementation. The 2013-2015 health sector MTEF was delivered on time and the 2012 performance report validated. Considering that the MOH opted for the gradual establishment of regional health sector MTEFs, three regions were accompanied during this fiscal year by the H2S Component: these include the Kolda and Thies regions which completed the process with the validation of their regional health sector MTEFs and the Kaffrine region whose document is awaiting validation. The H2S Component also provided DAGE/MOH with assistance to prepare its annual financial report for 2012 and collect financial data for 2013. The process of introducing the health sector MTEF is currently being reinforced with the implementation of public finance management reforms at the country level following adaptation to the related UEMOA directives.

Finally, accomplishments were noted under the sub-component "Coordination of the USAID Health Program". Coordination of USAID Health Program interventions was enhanced with the development of the first integrated action plan of the Health Program as well as the direct financing procedures manual aimed at adapting USAID's assistance delivery methods to the regional and local levels. The integrated action plan is now the tool being used by the Health Program's Steering Committee to summarize the Program's commitments and implementation of its activities. Furthermore, regional bureaus of the Health Program now rely on the integrated action plan to fully play their role, support the development process and monitoring of annual work plans of health districts and medical regions, and to inform local stakeholders on the various commitments of the USAID Health Program's five components.

Key constraints

One of the key constraints faced by the H2S Component in Year 2 was the slow implementation of reforms relating to the MOH reorganization process with the rearranging of central services and the conversion of medical regions into regional health directorates. This reform, which is yet to be effective, redistributed the missions and roles of central services working with the Component; moreover, it also delayed the preparation of job descriptions for members of the regional team and

the training guide on administrative management at the regional level. To address this issue, the Component, pending the signing of the decree on the reorganization of the MOH, put in place a support mechanism for the MOH to draft implementing orders and job descriptions for managerial positions at central and regional services.

Significant delays were also noted in the implementation of activities relating to the national plan on family planning as a result of the inadequate capacities of DSRSE in terms of human resources, organization and coordination. This issue is not unique to the H2S Component and has led most TFPs providing support to FP activities to assign a focal point to this department. The H2S Component has made available a resource person from Group ISSA to ensure enhanced coordination in collaboration with the other USAID Health Program implementing agencies.

1.2. Sub-Component A: Management and health systems at regional and district levels

Signing of PBF contracts in the health district of Kolda

1.2.1. Health system governance and leadership

- ***Training of medical regions and health districts on health governance***

During Year 2, training workshops on health governance were jointly conducted with DPRS for RHMTs and DHMTs in the Component's ten intervention regions. These workshops were attended by EPS staff, local government units, health committee members, ARDs and MHOs. The notion of health governance and its areas of intervention were discussed. Participants identified governance-related difficulties and proposed solutions adapted to their context. Ten (10) RHMTs and fifty two (52) DHMTs were hence trained on health governance: two hundred and ninety seven (297) individuals comprising mainly RHMT and DHMT members.

Support was provided for data collection on good governance indicators conducted by DHMTs and RHMTs at all service delivery points in the regions covered. A total of 891 SDPs were visited. Following this exercise, fourteen (14) health district-level indicators and six (6) medical region-level indicators were updated. The indicators were gathered and consolidated by DHMTs and RHMTs.

- ***Functional consultative platforms at the regional level***

During Year 2, the H2S Component provided support to four regions for the establishment of consultative platforms. These include the regions of Thiès, Louga, Kaffrine and Kaolack. Apart from Louga, consultative platforms are operational in the other three regions and the Component is providing support for the organization of periodic meetings.

1.2.2. Capacities in planning, management and monitoring

- ***Utilization of ORCAP tool in all intervention regions***

Utilization of the ORCAP tool was extended to three new regions in the H2S Component's intervention zone. Following the revision of ORCAP and its approval by DPRS/MOH as a tool to assess the capacities of medical regions and health districts and for planning purposes, DPRS and FHI360 put up a team of ORCAP trainers. In addition to the southern regions (Sédhiou, Kolda and Ziguinchor) which had already received training, three other regions in the intervention zone were enrolled (Kaolack, Thiès and Louga). Training workshops for RHMTs and DHMTs were hence organized and attended by one hundred (100) individuals in the Kaolack (35), Thiès (35) and Louga (30) regions. The training focused on analyzing performances of medical regions in relation to the 6 pillars of HSS, which helped identify priority needs and develop an ORCAP action plan for each region. Subsequently, the Component, in collaboration with DPRS, provided assistance to RHMTs and DHMTs in these six (06) regions to utilize the ORCAP tool. Activities contained in the ORCAP action plan were revised and analyzed depending on their level of incorporation into the 2013 AWP as well as their implementation level. Monitoring of ORCAP in the Kaolack, Thiès and Ziguinchor regions helped to assess implementation and status of activities: the percentage of ORCAP activities incorporated into action plans of regions are 86% for Thies, 52% for Kaolack and 100% for Ziguinchor.

- ***Support to annual work plans of health districts and medical regions***

The H2S Component, in an effort to enhance the quality of AWPs of medical regions and health districts, provided support for the organization and holding of training workshops on the AWP management guide. With the exception of Kaffrine, all RHMTs and DHMTs in intervention regions were trained on the AWP management guide. This orientation focused on the context and objectives of the guide, challenges in the health planning process, the conceptual framework and development cycle, and on how to fill-out the various forms of the AWP template. Two hundred and one (201) RHMT/DHMT members were trained.

A total of thirteen (13) out of the fourteen (14) regions in Senegal received various support from the Health Program to prepare their 2013 annual work plans (except for Matam). Beforehand, the Component had organized a workshop to develop the Program's integrated action plan, which consolidates preliminary action plans of the USAID Health Program's five components. The integrated action plan facilitated support for the development of AWPs of responsibility centers: teams composed of regional advisers accompanied all 52 districts and 10 medical regions in the intervention zone to prepare their 2013 AWPs. Regional consolidation workshops were held and attended by DPRS and DAGE, regional bureaus and other stakeholders such as local government units, ARDs, RHMT/DHMTs and EPS staff. AWPs of the various responsibility centers in each region were amended and validated during these workshops. In addition to regions covered by the H2S Component, the Health Program provided support to the regions of Saint Louis, Kédougou and Tambacounda for the development of their AWPs.

Quarterly workshops to monitor AWPs of medical regions and health districts were organized in intervention regions. The level of implementation for the first half of 2013 and difficulties encountered were discussed. These mainly include: (i) the implementation of unplanned activities from the central level, (ii) delays in the commencement of activities, and (iii) the non-availability of financing awaited from certain partners. Regions covered under the direct financing initiative were

late in holding their AWP monitoring workshops due to delays in the commencement of the initiative.

Within the framework of monitoring and supervision activities within intervention regions, regional bureaus accompanied medical regions and health districts in the quarterly supervision by RHMTs of districts. The performances of priority programs were assessed during these supervision visits and health data gathered. Support was provided for the organization of quarterly coordination meetings of medical regions and this facilitated discussions on AWP activity monitoring, difficulties encountered and corrective measures.

- ***Annual joint portfolio reviews held in intervention regions***

As in Year 1, the H2S Component provided support to ten (10) regions in its intervention zone to prepare and organize their annual joint portfolio reviews (JPR) attended by all actors in the health sector, namely, administrative authorities, local government units, heads of departmental services, development partners, NGOs and civil society. Medical regions were able to evaluate their 2012 activities and share regional performances with all health sector stakeholders.

- ***Accounting and financial management training in intervention regions***

In collaboration with DAGE, FHI360 and PAGOSAN, eight (8) training sessions in financial management were organized for medical region and health district managers and planning officers in Diourbel, Louga, Fatick, Dakar, Kolda, Ziguinchor, Kaffrine and Sédhiou. A total of eighty six (86) participants attended. Orientation workshops were also held for the RMOs and DMOs of Kaolack, Kolda, Fatick, Kaffrine and Sédhiou. Participants familiarized themselves with management documents, discussed best practices, acquired a better understanding of their roles and responsibilities in the management of funds as well as the need for a greater involvement of administrators in the preparation and monitoring of AWPs. The effectiveness and functioning of the accounting system established in health districts and medical regions following the training of managers were verified during post-training follow-up visits. Several follow-up visits were organized to assess the extent to which managers have taken ownership and are effectively utilizing these management tools and aids.

- ***Training of RHMT/DHMTs on fixed assets accounting in the three direct financing regions***

A fixed assets accounting manual describing procedures for the management of fixed assets of the Government, local government units and public institutions was developed. The capacities of DHMT/RHMTs in the Thiès, Kaolack and Kolda regions in fixed assets management were enhanced, the roles of the various stakeholders discussed, utilization of the various management tools explained and action plans to improve management of fixed assets developed. These workshops were attended by regional hospital directors, health education officers of Mbour and Tivaouane, DMOs and heads of regional social action and hygiene services in the three regions. A total of fifty nine (59) participants attended.

- ***Effective start of the direct financing pilot phase***

The direct financing initiative was launched in the pilot regions of Kaolack, Kolda and Thiès with a view to contributing to the adaptation of USAID's assistance delivery methods to the regional and local levels in the health sector. Box A1 presents a summary on the introduction of the direct financing initiative in the three regions.

Box A1: Introduction of direct financing in the Kaolack, Kolda and Thiès regions

FD objectives. The main objective of the direct financing mechanism is to contribute to adapting the way USAID/Senegal delivers its assistance to strengthen the decentralization of health services and performance-based management in the health sector in accordance with the strategic orientations of the 2009-2018 PNDS. Specific objectives are: (i) Contribute to strengthening the decentralization of health services; (ii) Improve the planning, budgeting and implementation process of health interventions at all levels of the public health system; (iii) Increase transparency and accountability in the health sector; and (iv) Strengthen the management capacities of medical regions, health districts and local health actors.

Preparatory activities. Development of the direct financing mechanism was entrusted to an inter-agency working group. The mechanism was hence jointly developed by the Health Program's implementing agencies. USAID and the Ministry of Health were involved in various stages of the development process to provide guidelines and ensure that the mechanism is adapted to their respective needs. Following a broad consensus (USAID, implementing agencies, MOH, medical regions), a concept paper and a procedures manual were developed to guide the implementation process. A contract template (implementation letters) based on a fixed amount reimbursement agreement associated to each milestone was developed to serve as a contracting instrument between all implementing agencies and each medical region.

Implementation. Several stages have been reached in the implementation of the direct financing mechanism in the Kaolack, Kolda and Thiès regions:

- *Development of AWPs:* The 5 components of the USAID Health Program participated in workshops to develop 2013 AWPs of regions, which serve as the basis for the identification of activities eligible for direct financing in each region.
- *Identification of milestones:* A workshop was held in January 2013 to provide baseline data for 2012, determine 2013 targets and define milestones as well as deliverables.
- *Contract documents:* Contract documents were prepared on the basis of milestones and deliverables. Contracts between the five agencies and each of the three medical regions were signed in late April.
- *Introduction at the regional level:* Orientation sessions on the principles, pillars and terms of the contract were conducted for staff of the Health Program's 3 regional bureaus and health management teams in the 3 medical regions (including members of regional validation committees). Medical regions signed performance contracts with each of their districts to ensure that the latter are held responsible for contributing to performance indicators. A regional validation committee (CRV) of milestones was established in each region by order of the Governor of the region.
- *Payment of the first milestone:* At the end of the first implementation quarter, regional validation committees met to validate the first milestone and transmit reimbursement requests. Thiès and Kaolack were paid in June and Kolda in July.

1.2.3. Performance-Based Financing

- ***PBF mechanisms are implemented in seven (7) health districts***

Support given by the H2S Component to the MOH for implementation of performance-based financing enabled the finalization of first year activities as well as the preparation and start of phase 2 activities of the pilot project.

Support to the independent verification system. During Year 2, the Component helped the MOH train all those involved in the verification of PBF Phase 1 data. These include members of the audit firm and CBOs selected, members of joint verification missions, and members of CRGs in the Kaffrine and Kolda regions. Three important points were discussed during this training: the work to be accomplished in health facilities by the joint mission, the patient survey and counter-checks. Following this phase, three verification missions were organized for the following quarters: April-June 2012, June-September 2012 and October-December 2012. Subsequent to these missions, three household surveys were conducted as well as three data reconciliation workshops. Cross-checking missions were also conducted.

For the second phase of the project, one of the recommendations adopted at the national review was to entrust verification missions to CRGs, with each CRG in charge of verifying data in a region other than their own. Hence in September 2013, a training workshop was organized in this regard for CRG members and resources persons comprising technical staff who could provide support to CRGs. The first verification mission conducted by CRGs was organized in September in the districts of Kaffrine and Kolda. Findings of the verification mission are summarized in the table below.

Summary of verified performances of health posts and health centers in the districts of Kolda and Kaffrine: Basis of PBF bonus payment

Performance measure	Kolda			Kaffrine		
	Number of HP/HC under PBF contract	2013 Quarters		Number of HP/HC under PBF contract	2013 Quarters	
		January-March	April-June		January-March	April-June
A. Maternal, newborn and child health						
1. Number of children under one year of age who are fully vaccinated	22	1508	1488	14	1314	1783
2. Number of children under two years of age who have been weighed 3 times during the quarter	22	1762	2948	14	9637	9275
3. Number of children aged from 6 months to less than a year who have received one vitamin A dose	22	508	903	14	0	435
4. Number of childbirths attended by qualified healthcare personnel	22	1101	886	14	162	872
5. Number of new users of family planning services	22	1334	1188	14	918	710
6. Number of women who have had a post-natal checkup	22	1621	1432	14	646	1360
7. Number of pregnant women who have been screened for HIV during pre-natal visits	21	1025	1354	14	1339	2277

Summary of verified performances of health posts and health centers in the districts of Kolda and Kaffrine: Basis of PBF bonus payment						
Performance measure	Kolda			Kaffrine		
	Number of HP/HC under PBF contract	2013 Quarters		Number of HP/HC under PBF contract	2013 Quarters	
		January-March	April-June		January-March	April-June
8. Number of pregnant seropositive women under ARV treatment	1	6	7	0	0	0
B. Disease control						
1. Number of pregnant women who have had 2 doses of SP (IPT2)	22	1003	1011	14	1101	1010
2. Number of identified TB cases	1	29	44	0	0	0
3. Number of smear-positive PTB patients who have been declared as cured	1	20	21	0	0	0
4. Number of children aged less than 5 years of age who have been properly treated for uncomplicated malaria	21	277	122	14	20	14
Monthly data aggregated per quarter and pilot district.						

Support for the organization and holding of the first PBF national review. The first national review was held in February 2013 and was attended by all stakeholders involved in PBF implementation. First year performances of the pilot phase were presented and validated. Box A2 below presents a summary on this first PBF national review.

Box A2: National review of performance-based financing implementation

The national review in the PBF cycle. The procedures manual provides for semi-annual review activities and revisions in the cycle of the PBF pilot project in Senegal. The first national review was conducted eleven months after the start of the initiative and marks an important step towards further implementing the project.

Objectives of the first national review. The general objective of the national review is to: Identify problems encountered during project implementation and propose corrective measures. Specific objectives are to:

- ✓ Share the results of the Preparatory Committee's work with implementing stakeholders to ensure that the appropriate measures are taken;
- ✓ Assess the institutional framework;
- ✓ Make recommendations to enhance performances of districts and develop a suitable institutional framework.

Participation of stakeholders. The first PBF national review was chaired by the Secretary General of the MOH and was attended by Steering Committee members, local government units, the Ministry of Economy and Finance, technical and financial partners, medical regions and health districts concerned, social partners, representatives of beneficiaries and representatives of the project's management bodies. It provided a platform for regional actors (CRG members and beneficiaries) to share their experiences and discuss the pilot phase.

Results achieved. All issues and constraints relating to project implementation were discussed and recommendations made. Several results were obtained including: (i) Revision of PBF indicators and improvement of the quality checklist; (ii) PBF extension to other districts in the Kaffrine and Kolda regions; (iii) verification of PBF data conducted by CRGs and ensuring a cross-check performed by an NGO; (iv) Creation of a national PBF program to be housed under the General Directorate of Health (DGS) and headed by a Coordinator.

Support to implement the second phase of the pilot project. In addition to activities relating to the implementation of the PBF cycle, other activities concerning the second phase were also conducted this year:

Revision of PBF tools. During the workshop on the revision of the procedures manual and management tools, indicators for health facilities, DHMTs and RHMTs were revised and the checklist improved.

An active data collection exercise in the districts of Kaffrine and Kolda by DHMTs with the support of the Component's HSS advisers facilitated the updating of PBF benchmarks in SDPs that were not signatories in Year 1 as a result of the strike action in the form of information withholding. Furthermore, due to certain difficulties encountered during the first phase, three indicators were changed during the review exercise and baseline data had to be collected for the new indicators. As soon as these benchmarks were established, beneficiaries were updated on the revised tools and thirty eight (38) performance contracts signed in these two districts.

The baseline survey in the five project extension districts was conducted by CRDH to determine baseline references in the new extension districts in the Kaffrine and Kolda regions. This data collection exercise helped to define all PBF indicators in 77 health facilities within the five (5) extension health districts. NGO members of the consortium (Africare in Koungheul and World Vision in Malem and Birkelane) were called upon to assist in obtaining certain data relating to nutritional and weight status at the community level.

Training of beneficiaries on PBF. The Component assisted the PBF Program to train beneficiaries in the five newly-enrolled districts composed mainly of ICPs, midwives at health posts, health center staff and DHMT members. Hence, in addition to the forty nine (49) service providers in the districts of Kaffrine and Kolda, one hundred and fifty six (156) beneficiaries in the newly-enrolled districts were trained on PBF. In collaboration with the Community Health Component, the H2S Component provided assistance for the training of ASCs and matrons in the district of Kolda: a total of 117 participants including 60 ASCs and 57 matrons received orientation on PBF.

Negotiation of benchmarks and signing of performance contracts. Results of the baseline survey were presented and helped set 2013 targets for all indicators in each beneficiary facility and facilitated the signing of performance contracts between the RMO and heads of beneficiary facilities. Thirty eight (38) contracts were signed in the Kaffrine and Kolda districts in addition to the seventy seven (77) signed in the five new districts, bringing the total to one hundred and fifteen (115) contracts signed in all districts in the Kaffrine and Kolda regions.

Payment of bonuses to PBF project beneficiaries

Sixteen (16) beneficiaries, signatories to the first pilot phase of the project in 2012, received in 2012 bonuses for the three PBF implementation quarters. Significant delay was noted in the payment of bonuses as a result of the late verification process, which was in turn due to delays in the selection of the audit firm and CBOs. Hence for Year 1, beneficiaries received bonuses in the total amount of **23,*564,521 CFA francs.*** The holding of the PBF national review in February 2013 and changes made subsequent to the recommendations of this review led to the signing of performance contracts for 2013 during the third quarter. As a result, no payments were made using funds earmarked in the 2013 action plan.

Box A3: PBF in the health system

PBF and strategic purchasing. The Performance-Based Financing (PBF) pilot project in Senegal is designed to accelerate attainment of health-related Millennium Development Goals (MDGs) through a strategic purchasing approach based on the priorities of the 2009-2018 National Health Development Plan. The PBF benefits package includes high impact health services such as: maternal health, family planning, child health and combating communicable diseases. Targeted services are delivered at health posts and health centers, which are the frontline providers of the healthcare system accessed by the poorest segments of the population.

PBF and priority healthcare services. Specific objectives and indicators relating to healthcare services were developed to help assess performances of health posts and health centers. Performances of beneficiaries are measured and verified each quarter based on targets previously defined with each beneficiary in a performance contract and according to the following indicators:

1. *Immunization coverage rate of children aged 0-11 months;*
2. *Coverage rate for nutrition and weight monitoring of children aged 0-24 months;*
3. *Proportion of children aged between 6 and 59 months who have received two vitamin A doses;*
4. *Rate of skilled attendance at birth;*
5. *Rate of new users of family planning services;*
6. *Rate of post-natal consultations;*
7. *Proportion of pregnant HIV-positive women under ARV treatment;*
8. *IPT2 coverage rate for pregnant women;*
9. *Tuberculosis screening rate (health centers only); and*
10. *Rate of tuberculosis cases successfully treated.*

PBF and quality of healthcare services. In addition to the quantitative indicators, a checklist on "healthcare quality" was prepared. The checklist covers the various components of healthcare quality. Elements of the quality checklist are weighted in order to obtain a score for the quality of services. This score, expressed as a percentage, will act as a deflator to be applied to the quarterly cumulative amount of bonuses to be paid to health facilities in the district.

Alignment with public finance management reforms. The current government's commitment to implement UEMOA directives on the management of public finances, the increasing focus on strengthening performance-based management and extension of the use of performance contracts in the civil service contribute to improving the PBF policy environment in the health sector. The PBF pilot experiment therefore provides the Ministry of Health with time to adapt to this new environment. Consequently, the Ministry of Health has already begun developing a national program on performance-based financing to support the extension of PBF nationwide.

- ***Other achievements.***

Support to develop a PBF software program. In collaboration with Broad Branch, the H2S Component provided support for the conduct of two missions of a team of experts in charge of assisting the MOH develop a website for the PBF program in Senegal. The local developer was hence selected and collaborative work commenced. This enabled: the transfer of knowledge to the Ministry of Health's developer on the architecture of the PBF application; assessment of how existing applications work; identification of functionalities to be developed; exchanges on "best practices" in web applications; setting up of modus operandi for development and communication means. The IT unit of the MOH plans to host the application at the ADIE (national information technology agency) where all required parameters are available.

Assistance to evaluate and document the PBF project. Discussions are on-going between the MOH and ANSD for the PBF pilot project impact evaluation needs to be integrated into the continuous survey. It is worth noting that, in Year 3, the Component will accompany the MOH to conduct an

evaluation of the pilot project's implementation process, whereas the impact evaluation will be supported by the World Bank in extension regions.

Moreover, a team from the TRAction project financed by USAID and implemented by R4D and KIT conducted working visits as part of a collaboration with the PBF pilot project. Support to be provided by TRAction will focus on action-research activities on operational issues of the healthcare quality component. The project will therefore help the MOH develop a quality assessment instrument and implementation procedures for hospitals (EPS) in intervention regions, support the utilization of checklists in health centers and health posts as well as the utilization of the quality tool for hospitals.

CRDH is currently documenting the PBF process. The team participates in various activities at the central and operational levels. In partnership with SNEIPS, tours were organized to the Kaffrine and Kolda regions for information gathering and behavior change.

Support to organize departmental development committee (CDD) meetings in the five new districts. The Component helped organize five CDD meetings to discuss PBF in departments of newly-enrolled districts. These meetings were chaired by the *Préfets* and attended by administrative authorities, local government units, technical services, representatives of the medical region, DHMT members and ICPs. The PBF pilot project was discussed as well as the roles and responsibilities of stakeholders. The need to organize CLD meetings was stressed to ensure that local government units, health committees and other local actors receive better information on the project as well as the need to involve administrative authorities in the monitoring of PBF implementation. A total of one hundred and thirty four (134) CDD members (21 in Médina Yoro Foulah, 34 in Vélingara and Birkelane, 28 in Koungheul and 17 in Malem) were informed and made aware of the PBF pilot project.

Gradual extension of PBF to other regions with contributions from other financing sources. With a view to accompanying the MOH in the gradual extension of PBF to other districts, the Component participated in the formulation workshop of the health-nutrition program financed by the World Bank and whose main component is PBF support. This project will enable the MOH, in 2014, to extend PBF to the Ziguinchor, Sédhiou, Tambacounda and Kédougou regions. The Component's support was shifted towards the development of an action plan, finalization of the project implementation manual and of the scope of work of the independent body in charge of verifying PBF data. The Component also participated in meetings with the Department of Investments at the Ministry of Finance to discuss financial arrangements in the implementation of the project.

1.2.4. Challenges and solutions

Assistance provided by the Component for the training of regional actors on health governance, the holding of joint portfolio reviews and facilitation of regional consultative frameworks can allow local government units to play their part in full, in keeping with their responsibilities in the health sector as provided for in the institutional framework on the political and administrative decentralization of the country.

Limited capacities in planning, management and monitoring at the operational level is a major challenge in light of PNDS strategic orientations on health governance and performance-based management. The H2S Component is currently accompanying DPRS and DAGE strengthen capacities in health governance, planning as well as accounting and financial management of medical regions and health districts, where results in priority health areas are produced.

Strengthening management processes through accountability and transparency is imperative to help support the strategic direction of the 2009-2018 PNDS and the DPPD. Direct financing and performance-based financing activities are supported by the Component to strengthen accountability of RHMTs and DHMTs and equip them with the tools and means necessary to enhance their capacities and motivate healthcare workers.

1.2.5. Lessons learned

The development of high quality AWPs at the regional and district levels requires the presence of technical and financial partners during the planning process thereby enabling responsibility centers to have the necessary information in terms of support to be included in their plan.

Collaboration with central services of the MOH (DAGE, DPRS) is a necessary condition for making rapid progress in the development and ownership of new management and planning systems and tools and for their involvement at the regional and local levels: the training manual on health system governance, the ORCAP tool and the administrative and financial management system of medical regions and health districts are perfect illustrations.

PBF is bringing about a certain performance culture of providers resulting in a behavioral change and a focus on analyzing the quality and coverage of healthcare services as well as seeking local solutions.

Inadequacies in the accountability of CRGs in decision-making and activity implementation at the local level prolong time limits set for the various stages of the PBF cycle.

Experiences of the PBF pilot project already provide a basis for the MOH and the World Bank in the design of a Bank project to financially support PBF scaling up at the country level.

1.3.Sub-Component B: Social financing mechanisms

Members of the MHO of Ndiagne in Louga proudly displaying their membership cards

1.3.1. Favorable support frameworks

- ***An institutional framework for support to mutual insurance bodies adapted to the UEMOA regulation is set up***

In pursuance of this result, the H2S Component continued its support to the MOH to monitor the signing of draft decrees on the organization and functioning of ONAMS and the Guarantee Fund for mutual insurance bodies. The draft decrees were adapted to UEMOA regulations following a mission conducted in July 2012 and led by the UEMOA Commissioner for Social and Cultural Development to assess implementation of the community regulation in Senegal. Adoption of these drafts will contribute to strengthening the regulation governing MHOs in Senegal.

- ***A strategy to harmonize the organization of MHOs in consolidated risk pools at the departmental or district level is adopted***

In order to take this strategy forward, which would act as a springboard at the local level for the extension of Universal Health Coverage (UHC), the H2S Component, in collaboration with the Belgian Technical Cooperation, assisted the MOH in the development of the 2013-2017 action plan for basic UHC through MHOs. The action plan aims at extending health coverage to 65% of the population employed in the informal and rural sectors by 2017 in line with the target of the 2013-2017 national strategy for economic and social development. It was adopted at the inter-ministerial council meeting on UHC chaired by the Prime Minister and held on April 12, 2013.

Subsequent to this inter-ministerial council meeting on UHC, the official launch of the Universal Health Coverage Program by the Head of State enabled Senegal to reach an important milestone, which proves the political commitment of the new authorities to extend healthcare coverage to the

entire population, particularly those in the informal sector. The H2S Component helped the MOH prepare and organize this official ceremony to launch the national program on universal health coverage held on Friday September 20, 2013 (see Box B1 on the official UHC program launch ceremony).

Box B1: Launch of the Universal Health Coverage program in Senegal

On September 20, 2013, Senegal reached an important milestone demonstrating the strong political commitment of the Head of State and Government to achieve universal health coverage. Eighteen months after his election as President of Senegal, Mr. Macky Sall presided over the official ceremony to launch the Program towards Universal Health Coverage, which was attended by the entire cabinet, the National Assembly and all stakeholders. Following a campaign promise, the new President in his inaugural speech on April 3, 2012 declared: :"*Beyond a new determination to increase healthcare equipment, I intend to launch a program on universal health coverage in consultation with the relevant stakeholders, as well as an in-depth reflection on good governance in the health sector*". This declaration triggered a year of national consultations and policy dialogue on health and social action led by the Ministry of Health and Social Action and which resulted in the launch of the program for universal health coverage.

The program is based on four strategic pillars:

(i) Reform of "IPMs (healthcare insurance institutions)", social insurance bodies that provide health coverage to employees in the formal sector and their families;
(ii) Provision of basic universal health coverage for populations working in the informal and rural sectors through MHOs and the financial support of the Government and local government units;
(iii) Greater support to free healthcare initiatives targeting the elderly and pregnant women;
(iv) Establishment of a new free healthcare initiative for children under 5 years of age.

A subsidized mutual health insurance regime to provide coverage to informal and rural sector workers remains the strategic priority option for progressing towards wider health coverage. The Government's decision to prioritize the development of MHOs for a significant extension of healthcare coverage to the majority of the population is a key step towards harmonization of interventions of technical and financial partners. The MHO subsidy policy will contribute to enhancing benefits packages, expanding their membership base and extending coverage to the poor.

- ***Templates for MHO financial reports and technical reports are developed***

The H2S Component continues to assist in strengthening regulations and professionalism through adaptation of MHO management systems and tools to the UEMOA chart of accounts for mutual insurance organizations. In this regard, the Component has since the third quarter, provided CACMU with the services of a team of consultants for the development of an MHO management procedures manual. (See Box B2 on the MHO management procedures manual).

Box B2: MHO management procedures manual in the context of Universal Health Coverage

In 2005, the UEMOA Commission, with the technical and Financial support of the International Labor Organization (ILO), undertook to develop a regulatory framework for mutual insurance schemes. At the end of this process, a regulatory instrument was adopted including a special UEMOA regulation on the establishment of accounting rules for mutual insurance schemes (PCMS). This regulation calls for the adaptation of current management capacities of MHOs to support the gradual extension of health coverage. To address this concern, the H2S Component provided CACMU with a multidisciplinary team of experts comprising certified accountants, specialists in MHO development and in public finances to accompany the adaptation of the UEMOA chart of accounts for mutual insurance schemes to the Senegalese context.

This support resulted in the production of an administrative and financial management manual adapted to the UEMOA chart of accounts for mutual insurance schemes in the context of implementation of the Universal Health Coverage policy in Senegal. This manual is divided into four chapters dealing successively with the MHO institutional and regulatory framework, the definition of mutual health insurance and its functions, administrative management policies and procedures, accounting and financial management procedures, and procedures for the mobilization and management of public funds.

The manual will contribute to strengthening management capacities of MHOs, including their capacity to effectively manage subsidies from the Government and its partners. The manual takes into account requirements of UEMOA and Government of Senegal on accounting, administrative and financial management as well as on the utilization of public funds. It hence takes into account the various types of financial and accounting procedures as well as administrative aspects of activities that a mutual insurance body would have to conduct within the framework of its participation in providing healthcare coverage to its members with the support of the Government and of its partners.

The H2S Component also provided support to CACMU for the development of two training manuals to strengthen the capacities of MHO promoters. A training of trainers' manual was developed to speed up the establishment and expansion of MHOs: the manual will serve as a resource tool to train pools of regional trainers who will, in turn, train MHO action committee members throughout the country. As a supplement to the MHO management procedures manual, a training manual on the administrative, accounting and financial management of a mutual health organization is currently being developed.

The Component also provided support to DGAS to develop the process and tools for targeting the poor and vulnerable groups (PVG) within the context of UHC. This support led to the technical validation of the PVG identification form and categorization system, the information sheet on the disability and the grid for measuring vulnerability of children and orphans in difficult situations. This support is part of the process to develop a database on poor and vulnerable groups per region in the hope of providing them with healthcare coverage through targeted subsidies expected from the Government.

- ***Other achievements.***

Establishment of favorable support frameworks for financing mechanisms prompted the H2S Component to become involved in the technical validation process of Annex 4: "UHC support" of the implementation manual of the World Bank project on financing the health and social action sector in Senegal expected to commence in 2014. The WB project plans to contribute in the financing of activities aimed at strengthening UHC institutional and financing support frameworks, setting up MHOs in the four target regions, and providing healthcare coverage to poor people through MHOs. This involvement of the H2S Component in this WB support area is part of its

efforts to promote joint frameworks and mechanisms for targeting poor and vulnerable groups in the social sectors.

1.3.2. Management capacities of networks and MHOs

- ***MHOs are operational in all local government units in the three (3) focus departments***

The H2S Component's support to the MOH for the implementation of the DECAM approach in the pilot departments of Kaolack, Kolda and Louga yielded promising results towards reaching this milestone during this second year. Twenty two (22) new MHOs have been established in all local government units where none existed including eight (8) in Kolda, eight (8) in Louga and six (6) in Kaolack. Furthermore, the Component also helped to restructure twenty six (26) existing MHOs in the three demonstration departments including eight (8) in Kaolack, five (5) in Kolda and thirteen (13) in Louga.

Various support was provided by the Component to MHO initiatives in the demonstration departments of Kaolack, Kolda and Louga. All MHOs were equipped with management tools. Their administrators were trained on accounting, financial and administrative management: 460 administrators were trained through the organization of thirteen (13) training workshops in the three demonstration departments. Significant progress has also been made in the implementation of awareness-raising and membership recruitment plans. These activities led to the recruitment of 18,242 new members in the three departments, i.e. 12,704 families in the Department of Kolda, 3,167 families in the Department of Louga and 2,371 in the Department of Kaolack.

The new parameters proposed under the DECAM strategy largely explain the sizeable membership of new MHOs in the three demonstration departments: benefits packages and policies on dues and subsidies. The standardized benefits package proposed under the DECAM project includes all services provided in health posts and centers including services relating to family planning, maternal health, child health and malaria prevention and control, whereby MHOs cover 80% of costs. The supplementary package offered for hospital services covers out-patient healthcare (80% of costs are paid by the MHO), hospitalization and surgical procedures including caesarean sections (100% of costs are paid by the MHO). 80% of costs for generic drugs and 50% for specialty drugs are paid by the MHO. An increase in membership rates is expected with the start of the Government subsidy; the first checks were handed to the presidents of regional federations at the official launch ceremony of the UHC program.

- ***A risk-pooling mechanism is developed to share high risks and professionalize risk-management in each of the three (3) focus departments***

Significant progress was also made towards reaching this milestone through support to organize CDS meetings and to establish departmental MHO unions in the three demonstration departments. The H2S Component provided assistance for the organization of six CDS meetings, i.e. two per department. These meetings were each chaired by the *préfet* of the department and were attended by over fifty participants comprising representatives of the Ministry of Health and Social Action (CACMU and DAGE), local government units, heads of decentralized technical services, MHOs and development partners. The Component supported the process to establish departmental unions, which will be the organs in charge of managing the risk pool at the departmental level. The departmental union of MHOs in Louga was established on September 30, 2013 under the supervision of CACMU. Workshops to develop draft statutes and rules of procedure were organized

in the departments of Kolda and Kaolack and constitutive general assembly meetings of the departmental federations are planned in October 2013. (See Box B3)

Box B3: Implementation of DECAM in demonstration departments

The H2S Component is currently providing the MOH with support to test an MHO establishment and organization model with a view to setting up a network at the departmental level for the extension of healthcare coverage to the informal and rural sectors through the DECAM (Decentralization and Extension of Healthcare Coverage) approach. The DECAM approach is based on the establishment of an MHO in each local government unit and the establishment of a departmental MHO union with the support of the Government and local government units. It is at the core of the universal health coverage program developed by the Government of Senegal to significantly increase healthcare coverage to the population employed in the informal and rural sectors.

Key implementation instruments of DECAM at the operational level include departmental monitoring committees (CDS), MHO action committees and MHOs in local government units and departmental unions of MHOs. The CDS, chaired by the *préfet*, serves as a platform for sharing experiences, encouraging healthy emulation among peers and mobilizing the leadership and commitment of stakeholders from different sectors to support and monitor implementation of health insurance coverage in the department.

MHO action committees are established in each local government unit to promote new MHO projects. Each action committee is composed of about twenty leaders of community-based organizations trained on raising awareness of populations on mutual health insurance, the recruitment of members, identification of benefits packages and determination of membership fees, drafting of statutes and internal regulations, and organization of the constitutive general assembly meeting of the MHO. The mandate of the MHO action committee ends with the holding of the constitutive general assembly meeting and the election of MHO executive bodies' members.

Departmental MHO unions are the operational platforms of risk pooling mechanisms at the departmental level as they manage the supplementary package and help ensure a professional management of MHOs through their technical management units. They also serve as a relay in the management of government contributions to the financing of MHO membership dues through partial and targeted subsidies.

- ***MHOs and MHO networks in the entire intervention zone of the Component are functional***

During the second implementation year, the H2S Component continued its support to strengthen existing MHOs and MHO networks in its other intervention zones. Fifty four (54) MHOs hence received direct support in terms of strengthening the capacities of their administrators, particularly in administrative and financial management and accounting. Support was also provided for the organization of ordinary general assemblies of MHOs, planning workshops and the conduct of awareness-raising campaigns to expand their membership base.

Furthermore, all ten (10) regional federations in the project's intervention zone received support for the convening of statutory meetings and for activities to monitor, provide advisory-support and identify the needs of MHOs, particularly those that were facing difficulties. The Dakar regional union received specific support for the finalization of its information system. Direct support was also provided to five (5) departmental unions (Diourbel, Bambey, Touba, Rufisque and Pikine) and five (5) district unions in the Thiès region.

- ***Other achievements.***

The H2S Component provided support for the implementation of the DECAM project in the new departments within its intervention zone through the organization of meetings of regional development committees (CRD) to discuss the main orientations of the action plan with community-

based stakeholders. This action plan is the centerpiece of the Ministry of Health's UHC implementation strategy paper. CRD meetings will be followed by Departmental Development Committee (CDD) meetings in UHC demonstration departments.

1.3.3. Coverage of vulnerable groups

- ***PLWHA support project.***

The H2S Component participated in meetings of the select technical committee established by the national steering committee to monitor implementation of recommendations of the assessment study. Key recommendations of the assessment study were discussed during these meetings and a plan adopted to consolidate the project in Kaolack. At the local level, the regional bureau of Kaolack took part in the activities of the regional management committee in charge of implementing the project. The select technical committee determined, in collaboration with partners concerned, the modalities for the extension of the project to the Ziguinchor and Kolda regions and adopted the implementation plan.

- ***Coverage of vulnerable groups***

The Component continued and strengthened its support to other initiatives for the coverage of vulnerable groups. It continues to provide support for the coverage of children and poor people through the MHO for retired railway workers, widows and orphans, the MHO Yombal Fajju ak Wer, the MHO for Koranic school children in Thies, and the MHO Al Birou wa Takhwa of Guediawaye-Pikine in the Dakar region. It also helps monitor the initiative to provide coverage for the poor and vulnerable groups through the equity fund set up by the Belgian Technical Cooperation in the Kaolack, Kaffrine, Fatick and Diourbel regions. Other initiatives are on-going under the "Millennium Villages Project" in Louga and the World Vision child sponsorship program in the Kolda, Kaffrine and Fatick regions. At total of 31,876 poor and vulnerable people are receiving healthcare coverage through MHOs.

1.3.4. Challenges and solutions

The new context of community-based health insurance is heralding a paradigm shift which will give the Government and public stakeholders a prominent role to play in steering the process. This therefore raises the question of whether this responsibility can be carried by CACMU in light of the institutional limits in relation to its statute, its organization and its human resources. Establishment of regulatory support frameworks (ONAMS, FG) recommended by the UEMOA community regulation could bridge this gap.

With the Government's decision to extend the demonstration phase to ten new departments, UHC financing requirements will become increasingly higher in the years ahead. The significant flow of Government resources to MHOs calls for the establishment of a mechanism that will guarantee the regularity of transfers and transparency of financial transactions in compliance with procedures on the management of public funds. However, MHOs do not yet have the capacity to meet these new requirements. Operational technical management units of departmental MHO unions could help strengthen the management capacities of MHOs.

Implementation of the various UHC components will probably result in a considerable increase in the use of healthcare services in a context where the lack of qualified human resources and

equipment is manifest. The Government should therefore be advocated to speed up implementation of programs aimed at strengthening the delivery of healthcare services in terms of recruitment of qualified healthcare personnel and procurement of sufficient equipment for health facilities so as to anticipate on the demand for healthcare services as a result of UHC implementation.

1.3.5. Lessons learned

The political commitment of the new authorities to promote universal health coverage is creating an enabling environment for the development of MHOs and contributing to redirecting the interventions of technical and financial partners towards the health coverage sector.

Mobilization of administrative authorities, local government units and technical decentralized services was critical in the implementation of the DECAM approach in demonstration departments.

The empowerment of local governments and healthcare providers in the implementation of the DECAM project is resulting in a clearer understanding of their roles and responsibilities in the development of MHOs and the expansion of health coverage.

1.4 . Sub-Component C: National level health policies and systems

1.4.1. Policies and reforms

Policies, reforms and initiatives supported by the H2S Component in Year 2 relate to key areas and programs such as community health, the medical supplies procurement policy and family planning. The Component's approach consisted of accompanying the relevant services of the MOH throughout the process involving all stakeholders including the community of TFPs.

- ***Community health policy***

The decision of the MOH to develop a community health policy was taken during the 2012 fiscal year at a time when the Health Program's inter-agency coordination group had decided to include this theme on its work agenda for the first year. Components were hence invited to join the technical committee established by the EIPS to develop the community health policy paper. In this regard, H2S and ChildFund collaborated to provide coherent technical and financial support to the MOH throughout the process. The strategy adopted by the committee was to first select a consultant to conduct a situational analysis prior to embarking on the policy development phase during which four thematic groups were created (Institutional framework, Intervention areas, Motivation, Financing). Reports of thematic groups were consolidated by a select committee which drafted and submitted the preliminary document to the technical committee for validation and presentation to the EIPS.
Coordination of this activity was ensured by the former Division of Primary Health Care prior to it being replaced by the Community Health Unit. Specifically, the second phase in the development of the policy paper coincided with the establishment of the Community Health Unit within the General

Directorate of Health. Results of thematic group work were used to give substance to this Unit. The MOH currently has a community health policy (reference framework for community-based interventions) as well as a structure adapted to implement this policy. The next step consists of developing an operational plan to implement this policy and serve as a basis for programming community health activities in AWPs of the MOH. H2S will continue to support implementation of this policy. Consequently, the Component's action plan for FY 2014 has earmarked funds for community health.

- ***Advocacy for family planning***

The Component is providing support for the MOH to implement the national FP plan through Group ISSA. To this effect, H2S provided DSRSE with the services of a specialist to assist in the organization of activities, particularly those financed by the Component. The Component provided support during the entire process of revising FP advocacy tools to the validation of new tools. Also, due to the delay incurred in the implementation of activities to raise awareness of parliamentarians and locally-elected officials and in the organization of semi-annual regional FP reviews, arrangements were made with DSRSE to accelerate implementation of these activities in early 2014.

- ***National consultations on healthcare and social action***

The H2S Component was very active in the organization of the national consultations on health and social action (CNCAS) in January 2013. The Component provides constant support to the MOH throughout the lengthy process of preparing and holding the CNCAS, from the preparation of the terms of reference to the production of the final report. A consulting firm was recruited to assist the steering committee and advisers of the Component actively participated in the work of thematic groups.

Box C1: National consultations on healthcare and social action

The event was a major turning point for the Ministry of Health and Social Action as it translated into concrete action the political will of the Head of State to initiate national consultations in this area. The Ministry successfully organized these consultations in January 2013 following nine months of preparation.

The objective of the national consultations on health and social action was to "build national consensus on reforms to be undertaken in the health and social action sector to sustainably improve access to quality healthcare in a context of improved governance and performance-based management". The specific objectives were to:

- Identify reforms to be undertaken for improved health governance at all levels of the health system;
- Establish a system to operationalize healthcare cards that will ensure a dynamic and equitable distribution of healthcare service delivery as well as the performance of and fair access to healthcare;
- Create the legal, material and technical conditions to accelerate implementation of the national strategy on the expanding health coverage for sustainable universal health coverage;
- Identify the appropriate strategies to be implemented to improve disease prevention and control through a multi-sectoral framework where the relevant ministerial departments and other non-governmental stakeholders will play their part in full;
- Ensure better protection for people with disabilities and other vulnerable groups through an integrated system built on the conclusions of the social action consultations and consistent with the healthcare policy.

Participation in the consultations was broad and of high quality: Representatives of ministries, the National Assembly, local government units, universities and health training institutions, associations, labor unions, private sector and development partners. The opening ceremony was chaired by the Head of State Macky Sall.

Key measures adopted at the national consultations were twenty (20) in number. Significant progress has been made in the implementation of two of these: (i) Measure 6 on community health, and (ii) Measure 19 on accelerating expansion of health insurance coverage.

- ***Strengthening the capacities of the EIPS***

The Component is providing support to the MOH for an increased availability of drugs by strengthening the capacities of the PNA in the areas of supply and distribution of essential drugs. Two key results were achieved in 2013: finalization and validation of the PNA procurement manual (see Box C2 below) and development of the management and information system. H2S provided further assistance to PNA by helping the latter develop its strategic plan. The process was initiated during the fourth quarter and will be pursued in FY 2014.

Box C2: PNA procurement manual

Development of the PNA procurement manual was entrusted to the consulting firm DMA, recruited by the Component through PATH. PNA led this activity from the preparation of the consultant's scope of work to the validation of the final document in April 2013.

The following is stated in the preamble of the manual: *"The purpose of these regulations, taken pursuant to the provisions of the NCMP, is to provide those responsible for the procurement of goods and services at the PNA, with information on the procurement rules and processes to be followed as well as on other related services such as insurance and transport. The rights and obligations of PNA and suppliers of goods, works and services are governed by the tender documents and contracts signed between the latter and PNA and not by these regulations".*

The objective of the PNA procurement manual is to "ensure the geographic availability of MEGs and other health products taking into account all NCMP requirements with due regard to economy and efficiency". Procedures will enable those in charge of procurement and stock management to:

- Comply with the procurement process,
- Familiarize themselves with the key stages in the supply chain,
- Familiarize themselves with the principles for the selection of products,
- Quantify needs for drugs and other health products,
- Monitor the quality of drugs,
- Conduct a physical inspection of products at delivery,
- Perform best storage and distribution practices,
- Familiarize themselves with the distribution circuit,
- Involve all persons who should be involved in the process,
- Keep stock management tools up-to-date,
- Monitor performance indicators on stock management.

The procurement manual was widely distributed. Users at the PNA and PRAs were trained on these new procedures. The manual was supplemented by the MIS, whose development was entrusted to the consulting firm SENINFOR also recruited by the Component through PATH.

- ***Other achievements.***

The Component contributed to the development of the ICT training plan of the MOH by providing financial support for the organization of ten (10) training sessions for 318 agents at the central and regional levels. These sessions were focused on the collaborative platform "workgroupsante" (166 agents trained) and office applications (152 agents trained).

1.4.2. Monitoring of the PNDS

- ***Preliminary health sector MTEFs***

The 2014-2016 preliminary health sector MTEF was developed by DAGE with technical support from the Component. However, it shall be noted that the MOH was informed in August 2013 by the MEF of the decision to replace the Medium Term Expenditure Framework (MTEF) with the Multi-Year Expenditure Programming Document (DPPD). This reform is part of efforts to harmonize public finance management within the UEMOA. The workshop to develop the first DPPD of the MOH was held in September 2013 under the auspices of DPRS. The contents of the DPPD and its implications in relation to the MOH's organization and the Component's support in the area of budgetary and financial reforms are described in Box C3.

- ***Health sector regional MTEFs***

Regional MTEFs were developed and validated for the Kolda, Thiès and Kaffrine regions. However, these regional MTEFs must now be adapted to fit the new DPPD context. The approach will not be modified.

- ***2012 performance report***

Finally, the Component provided financial and technical support to DAGE for the preparation of the 2012 health sector MTEF performance report. The process commenced with a workshop held on March 18, 2013 during which the draft report was produced. The final version was then prepared and sent to MEF on time. The 2012 performance report was the main working document of the Joint Portfolio Review held on June 17 and 18, 2013 at the Méridien President hotel in Dakar and chaired by the Minister of Health and Social Action.

Box C3: Multi-year Expenditure Programming Document (DPPD)

Introduction of the DPPD at the MOH is a priority considering the time limit set by MEF. The latter has requested that the MTEF be replaced by the DPPD by 2014.

The process to reform public finance management in UEMOA countries began in 2009 and the objective is to establish new regulations for a transparent and rigorous management of public resources. Indeed, the six directives adopted to ensure harmonization of public finance management within the Union relate to:

- *the code of transparency practices;*
- *the organic law on public finance;*
- *the general regulation on public accounting;*
- *national budget classification;*
- *national chart of accounts;*
- *national summary fiscal table.*

The DPPD of the Ministry of Health and Social Action includes, over a period of three years, appropriations for and expected results of each program based on the targeted objectives. Pursuant to article 12 paragraph 4 of the Finance Act 2011-15 of July 8, 2011, "a program includes funds for the implementation of an action or a coherent set of actions representing a clearly defined medium-term public policy".

This reform introduces major innovations in comparison with the MTEF. Firstly, the role of program managers is reinforced. Program managers are now "funds administrators" and "authorizing officers by delegation". The appointment of program managers will now be done by decree. Secondly, the structure of the DPPD introduces the notion of "actions". the program is conducted through a certain number of precise "actions", for which budgetary allocations are made.

Consequently, the H2S Component will have to rethink its support to the MOH for the implementation of budgetary and financial reforms and adapt it to the new context of DPPD. Capacity gaps have already been identified at the DPRS designated to steer this reform process. Furthermore, the roles and responsibilities of new program managers to be appointed should also be considered. The H2S Component will help the MOH

define these new roles and develop systems and capacities to address these new public finance management reform requirements in the health sector.

- ***2012 financial report of DAGE***

DAGE presented the first version of its 2012 financial report at the JPR in June 2013. The report will be completed by incorporating contributions from TFPs. The Component provided financial support to DAGE for data collection at the regional level.

1.4.3. Challenges and solutions

Completion of the MOH reorganization process. Reorganization of the MOH to create the conditions for performance is an imperative for successful implementation of universal health coverage as well as budgetary and financial reforms driven by the harmonization of public finance management within UEMOA.

Adaptation of the planning system to budgetary reforms. Replacement of the MTEF by the DPPD calls for a paradigm shift that is in line with performance-based management, particularly with regard to the way the budget is perceived in terms of efficiency in the allocation of resources and accountability.

Ownership of AWPs by all responsibility centers will require the fulfillment of financing commitments – another challenge to be met – and hence the importance of having an AWP validation system involving all stakeholders as well as an effective mechanism to monitor its implementation.

Quality assurance in budget allocation and expenditure monitoring. Considering that available resources are seldom sufficient to achieve the ambitious health objectives, the issue of budget allocation based on objective criteria is now a requirement especially since the goal of the DPPD is above all to ensure efficiency in budget allocation and complete transparency in the management of funds.

1.4.4. Lessons learned

The active involvement of the Component in the organization of national consultations on health boosted confidence levels between the MOH and USAID and also facilitated the validation of a number of approaches and initiatives relating to health governance and universal health coverage.

Flexibility of financing mechanisms is an asset for the successful alignment of aid to national priorities, provided that risks of redundancy in the allocation of resources are minimized through a joint integrated planning system.

1.5. Sub-Component D: Coordination and Monitoring/Evaluation

Inter-agency workshop to develop the Health Program's Integrated Action Plan

1.5.1. Coordination

During Year 2, Health Program coordination was consolidated with the development of an integrated action plan for 2012-2013 and the commencement of the process for 2013-2014. This new inter-agency coordination instrument reinforces coordination frameworks in existence since previous health programs: the Steering committee and Health Program regional bureaus.

- ***Meeting of the Health Program's Steering Committee***

The Health Program's Steering Committee met twice during Year 2. The first meeting, held on October 18, 2012 at the MOH conference room, discussed the accomplishments of Year 1 and perspectives for Year 2. The second, held on May 14, 2013, focused on the integrated action plan, new financing mechanism initiatives (PBF and DF), challenges and recommendations for a better implementation of program interventions.

- ***Regional bureaus of the Health Program***

Health Program regional bureaus continue to play a significant role in Program coordination. Regional bureaus provided support for the development of AWPs in the 10 regions of the Component's intervention zone (See section 1.2). The integrated action plan, shared beforehand with regional bureaus, served as a key tool for this support. Regional bureaus also held their quarterly coordination meetings to discuss implementation of activities of all five components as well as upcoming activities, make recommendations to improve activity implementation and finalize their activity reports. Regional bureaus also participated this year in quarterly coordination meetings of

medical regions and health districts providing both technical and financial support. These meetings are opportunities to share and discuss information for the effective implementation of activities.

Regional bureaus play a key role in the implementation of the direct financing mechanism at the regional level. They contributed in the development of the direct financing documents, the finalization of the procedures manual and implementation of direct financing activities. They played an important role in the identification of milestones and related indicators, which are the basis of direct financing contracting arrangements. They supported the introduction of direct financing in each of the pilot regions of Kaolack, Kolda and Thiès. Regional bureaus represent the Health Program and all implementing agencies at regional verification committees and monitor implementation of direct financing activities at the regional level.

A meeting was held in Dakar between Administrative and Financial Officers of the five components and Coordinators of regional bureaus to revise the operations manual of the Health Program's regional bureaus. A draft document was produced and will be submitted to COPs for validation. Furthermore, Administrative and Financial Officers of regional bureaus were trained on the "ISMS" tool, which aims to simplify accounting and financial monitoring through the electronic filing of supporting documents. This training program promotes effective collaboration by allowing the head office as well as the other bureaus of the H2S Component to have access to real-time financial information through the internet.

- ***Inter-agency Coordination***

Inter-agency meetings. During the second year, the Component organized several meetings of COPs including meetings held in the offices of the various components on a rotational basis. This system was initiated in May 2013. The rhythm of inter-agency coordination meetings was less intense in Year 2 compared to Year 1 during which many hours were devoted to inter-agency coordination meetings as a result of the management, planning and financing instruments that were being developed. Agencies have however undertaken to revitalize inter-agency coordination and have agreed that COP meetings will be held at more regular intervals and for shorter durations with a limited number of attendees.

COPs have identified six (6) common interest themes to revitalize inter-agency coordination: (i) communication, (ii) partnerships with Community-Based Organizations, (iii) the private sector, (iv) sustainability strategy, (v) Management system and tools, and (vi) RH/HIV integration. One or two agencies will take the lead for each theme and shall therefore prepare draft guidelines and scope of work prior to the establishment of inter-agency working groups for each theme as previously done in Year 1. However, the preparation of coordination themes and establishment of working groups were delayed during Year 2 but will be continued in Year 3. Other inter-agency meetings were held to develop the Health Program's integrated action plan.

Health Program's integrated action plan. The guidance note on integrated planning prepared in Year 2 provides for the development of a preliminary integrated action plan in October to enable regional bureaus to provide effective support for the development of AWPs of medical regions and health districts. Development and utilization of the first integrated action plan of the Health Program are summarized in Box D1.

Box D1: Health Program's integrated action plan for Year 2

The objectives of the integrated action plan are to ensure consistency of Health Program interventions, identify synergy actions to be developed and facilitate identification of interventions supported by all program components in annual work plans of medical regions and health districts. To achieve these objectives, implementing agencies of the program jointly developed a "guidance note on integrated operational planning" during Year 1 to guide the development of the joint integrated action plan by Health Program agencies.

The first integrated action plan of the Health Program was developed in Year 2. In October 2012, following the transmission to USAID of preliminary action plans for FY2013 by all CAs, the Component drafted and proposed to the latter the terms of reference of the workshop to develop the 2012-2013 preliminary integrated action plan in early November 2012. It was agreed that each component would send by email, one week prior to the workshop, the chronogram of its FY2013 preliminary action plan to the Abt COP who would ensure that each component has the 5 action plans. Also, action plans were to be prepared based on the approved template contained in the guidance note. During this workshop attended by all Health Program components, participants identified milestones per the Health Program's intermediate results and hence grouped together activities that contribute to their attainment. At the end of the workshop, the document was given to a select committee to ensure the completeness of information in collaboration with the agency and finalize the document: a first version of the preliminary integrated action plan was submitted on November 22. This preliminary version was revised and finalized following the development of AWPs of medical regions and health districts, validated by COPs and transmitted to USAID on February 18, 2013.

The preliminary integrated action plan was first utilized as a single document to present interventions of the program to regional bureau staff. The document was then utilized during AWP development workshops as a coherent series of information provided to facilitate identification of activities supported by the USAID Health Program to be integrated into AWPs.

The integrated action plan also provided the basis for discussions at the Steering Committee meeting for the first half of the fiscal year 2012-2013. A single presentation was made covering accomplishments of all Program components.

Two inter-agency meetings were held between August and September 2013 to make sure that agencies agreed on milestones before preparing their own action plans and to prepare for the development of the integrated action plan for Year 3. A first meeting on milestones of the Health Program's integrated action plan was held in early August at ADEMAS between monitoring and evaluation officers of the components: amendments were made and rewording proposed as well as the addition of a milestone on community health; furthermore, the recruitment of a consultant was proposed to facilitate the development of the preliminary integrated action plan. The second meeting on milestones was held in mid-September during which consensus was reached on a list of 20 milestones; furthermore, the scope of work of the consultant was validated and dates proposed for the convening of the workshop to develop the preliminary integrated action plan (October 23 and 24, 2013).

1.5.2. Monitoring/Evaluation

- ***Quarterly reports of the Component submitted to USAID.***

To ensure the regular monitoring of activities, the Component organized six coordination meetings this year and held a three-day retreat in March 2013 with all staff members. During this retreat, implementation of the 2013 action plan for the first half of the year was reviewed and priorities identified for the second half. New formats for reports and bi-weekly updates were also developed following observations received from USAID.

- ***Preliminary action plan and FY2013 budget prepared and submitted to USAID***

Annual action plans of the Component were prepared and submitted to USAID on time. The action plan for Year 2 was finalized after integrating observations made by USAID and amendments made during the development of AWPs of districts and medical regions. It was sent to USAID in January 2013. Regarding the action plan for Year 3, a workshop was organized from August 19 to 22, 2013 to identify, budget and select priority activities to be implemented in collaboration with partners at the Ministry of Health and Social Action. The preliminary annual action plan was sent to USAID in September 2013.

- ***Database and archiving.***

Database of the Component. The architecture of the Component's database was finalized this year and data relating to 2011-2012 activities entered. Second year data has been partially entered. The database helps to determine the implementation level of activities through objectively verifiable indicators.

Archiving of documents. The HSS file directory was created on the server to archive documents of the H2S Component. Most of the documents prepared during the first and second year have already been archived and the directory is continuously being updated.

1.5.3. Challenges and solutions

One of the major challenges in program coordination is the frequency of inter-agency meetings and internal coordination meetings (national office and regional bureaus) as well as the participation of regional bureaus in coordination meetings of medical regions and health districts. For monitoring, the issue is the availability of quality information on time. Regarding inter-agency meetings, the challenge could be addressed through exchanges between COPs, effectively convening meetings on a rotational basis which involves all components, and complying with established norms (duration of meetings, participants, frequency).

Regarding coordination at the national office level, despite the frequent trips of advisers and involvement of sub-contractors, the COP has managed to organize at least one meeting every other month while acknowledging that there may be justified absences. Regional bureaus have no issues organizing their own coordination meetings but should ensure better communication with medical regions to increase their participation in coordination meetings of medical regions and health districts.

1.5.4. Lessons learned

Communication and complying with standards are determinants of success in the implementation of activities. This has been demonstrated within the context of inter-agency coordination and updating of the Component's indicator levels. Through email exchanges, COPs were able to agree on dates, agenda items and venue for their meetings. Regional bureaus were able to provide information relating to medical regions, health districts and MHOs, and make the necessary amendments or provide the necessary explanations.

2. Constraints

- ***Major constraints***

One of the major constraints faced by the H2S Component in Year 2 was the slow implementation of reforms relating to the MOH reorganization process with the rearranging of central services and the conversion of medical regions into regional health directorates. This reform, which is yet to be effective, redistributed the missions and roles of central services working with the Component; moreover, it also delayed the preparation of job descriptions for members of the regional team and the training guide on administrative management at the regional level. To address this issue, the Component, pending the signing of the decree on the reorganization of the MOH, put in place a support mechanism for the MOH to draft implementing orders and job descriptions for managerial positions at central and regional services.

Delays have been noted in the implementation of planned activities in several areas of the H2S Component.

- Firstly, delays are noted in the implementation of the national plan on family planning as a result of the inadequate capacities of DSRSE in terms of human resources, organization and coordination. To address this issue, the H2S Component has made available a resource person from Group ISSA to ensure enhanced coordination of interventions in collaboration with the other USAID Health Program implementing agencies. The Component is also strengthening the decentralization, at the regional level, of activity implementation in support of the national FP plan.

- Secondly, delays are observed in the implementation of work plans at the district and regional levels due to the straddling of health district and medical region activities and those of the central level. To address this issue, regional bureaus are currently increasing their support for the development and sharing of quarterly work plans and monitoring implementation of annual work plans.

- Finally, delays have been noted in the implementation of activities in support of social financing mechanisms due to difficulties encountered by CACMU to meet deadlines for the implementation of planned activities. The Component is currently strengthening the decentralization of activity implementation in support of MHOs by relying on departmental monitoring committees and operational technical committees, which include regional development agencies, medical regions, health districts, and regional unions of MHOs.

- ***Specific constraints***

Specific constraints have been noted in sub-components of the H2S Component:

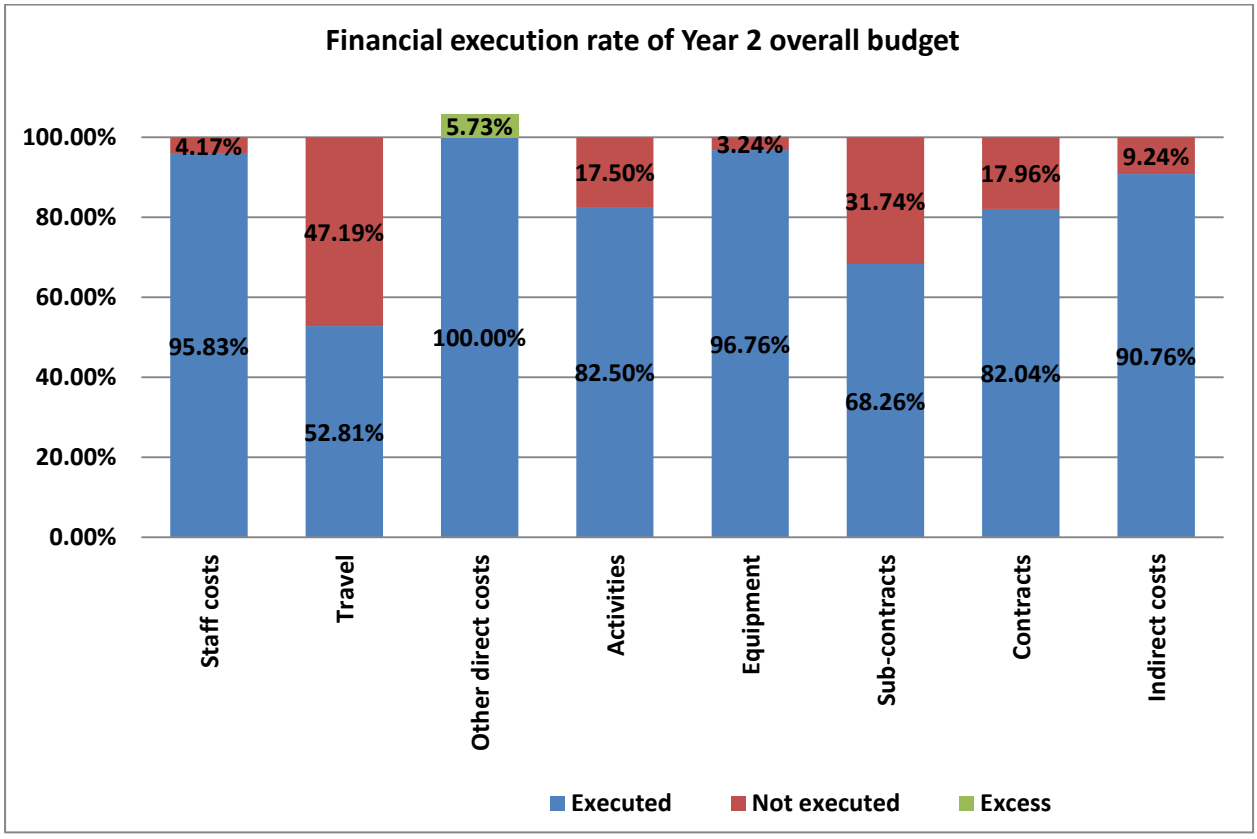
Delays in the signing of the Order establishing the national PBF program. Apart from the Coordinator, other members of the Program are yet to be appointed. This constraint could be lifted after meeting with the Director General of Health and his advisers, and drafting of the Order establishing the national PBF program.

The risk pool mechanism at the departmental level is not yet functional due to the delay in establishing departmental unions of MHOs and mobilizing Government subsidies. This constraint could be lifted with the holding of constitutive general assembly meetings of departmental federations, the adoption of procedures and the establishment by the MOH of a mechanism in charge of managing government subsidies under UHC.

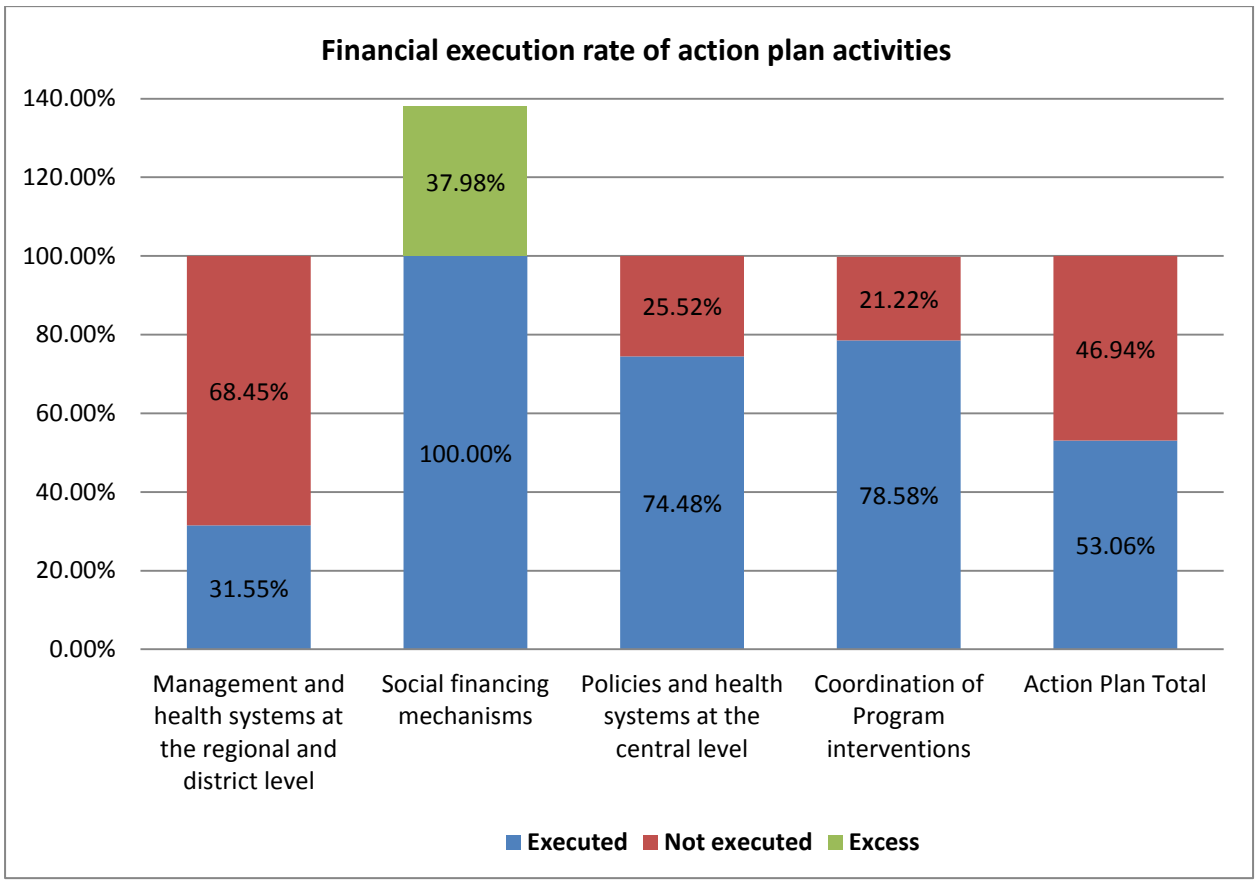
Development of resource allocation criteria by DAGE has also been delayed. The definition of resource allocation criteria and the development of a quarterly budget monitoring system are DAGE's initiatives that have experienced the most delays despite frequent reminders by the Component. Group ISSA has again been called upon to help accelerate the process and accompany this new momentum that the DAGE has generated.

3. Finances

At the end of the second year, total expenditures of the H2S Component amounted to USD 4,630,010 out of an annual budget of USD 5,101,374, representing an overall execution rate of 90.76%. This rate has increased by 20 points compared to the first year. This significant increase is due to a more favorable environment for the conduct of activities than last year, which was marked by a context of project start-up and the national political agenda.



The action plan for Year 2 mobilized financial resources earmarked in the overall budget for the implementation of Year 2 activities as well as unexpended funds from Year 1. The financial execution rate of the action plan is 53.06%. The financial execution rate of the action plan is explained by delays in the implementation of activities relating to the direct financing and PBF pilot initiatives, which account for a large portion of the Component's activity budget.


Financial execution rate of action plan activities
140.00%
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
68.45%
31.55%
37.98%
100.00%
25.52%
74.48%
21.22%
78.58%
46.94%
53.06%
Management and health systems at the regional and district level
Social financing mechanisms
Policies and health systems at the central level
Coordination of Program interventions
Action Plan Total
Executed
Not executed
Excess

4. Guidelines and priorities for Year 3

The annual action plan for Year 3 of the H2S Component was prepared taking into account changes in the sector and progress made during the first two years of the Component. The new political authorities have included governance and universal health coverage among the priority issues on their political agenda. Furthermore, central and regional services of the MOH are currently being reorganized. In order to fit its priorities to these changes, the MOH held national consultations on health and social action (CONSAS), which led to key recommendations and measures on health governance and universal health coverage. Key health coverage measures were discussed during an inter-ministerial council on UHC; furthermore, a UHC strategic plan was developed and resources earmarked to support its implementation. The Performance-Based Financing (PBF) initiative has made significant progress since the first national review and the lifting of the strike action to withhold information. The PBF initiative was extended to seven health districts in two regions and a World Bank project is being developed to extend PBF to four other regions as of 2014. Finally, USAID/Senegal is committed to implementing a package of reforms relating to the way it does business, including the *Implementation and Procurement Reform (IPR)* which introduces direct financing mechanisms at the central and regional levels with the support of the Health Program's implementing agencies.

The annual action plan for Year 3 will continue to set the stage for the H2S Component to seize opportunities offered by the changing environment to improve health system performance by focusing on the practical application of planning, implementation, management and financing instruments developed during the first two years.

Based on these general guidelines, the following priorities defined by the USAID Health Team directed the development of the 2013-2014 action plan:

- Nutrition activities;
- Implementation of the family planning action plan;
- PBF implementation and coordination with the World Bank program;
- Supply chain management assistance;
- Results/impact demonstrated through support to family planning, maternal health and child health interventions;
- Support to ensure universal health coverage;
- Implementation of direct financing activities;
- Coordination of regional bureau activities and integrated work plans.

Attachment 1: Financial report of the Component

Execution of the overall budget for Year 2

Description	Budget	Cumulative spending for Year 2	Balance for fiscal year 2	% of annual budget executed
Staff costs	$ 1 655 409.94	$ 1 586 454.70	$ 68 955.24	95.83%
Travel	$ 68 929.70	$ 36 398.74	$ 32 530.96	52.81%
Other direct costs	$ 515 290.39	$ 532 571.40	$ (17 281.01)	103.35%
Activities	$ 1 131 973.15	$ 933 931.20	$ 198 041.95	82.50%
Equipment	$ 10 342.65	$ 23 204.45	$ (12 861.80)	224.36%
Sub-contracts	$ 880 925.98	$ 852 348.30	$ 28 577.67	96.76%
Contracts	$ 165 369.27	$ 112 888.18	$ 52 481.09	68.26%
Indirect costs	$ 673 133.51	$ 552 213.87	$ 120 919.64	82.04%
Total Actual Costs	**$ 5 101 374.57**	**$ 4 630 010.84**	**$ 471 363.73**	90.76%

Execution of the budget allocated to the action plan for Year 2

Annual action plan of the H2S Component		Cumulative spending for Year 2	Balance for fiscal year 2	% of annual budget executed
Line of action	**BUDGET CFA F**			
Sub-Component A: Management and health systems at regional and district levels				
Stakeholders at medical regions and health districts are trained in governance and leadership in the 10 focus regions	16 071 000	20 457 198	(4 386 198)	127.29%
Job descriptions of RHMT and DHMT members available in 5 regions	2 250 000	-	2 250 000	0.00%
Functional consultative platforms in 5 regions	2 000 000	205 625	1 794 375	10.28%
ORCAP tool utilized in seven (7) regions	10 000 000	12 285 455	(2 285 455)	122.85%
Support provided to ten (10) medical regions for the development of AWPs	12 101 000	6 748 858	5 352 142	55.77%
Regional and district teams are trained on administrative and financial management in 10 regions	14 700 000	15 292 876	(592 876)	104.03%
Targeted staff in the 5 regions trained on the management of medicines	-	-	-	
Implementation letters for directing financing signed between agencies and 3 medical regions	102 281 000	25 351 929	76 929 071	24.79%
Annual joint portfolio reviews held in ten (10) regions	8 500 000	6 876 954	1 623 046	80.91%
PBF mechanisms implemented in seven (7) health districts	187 208 087	90 673 634	96 534 453	48.43%
Incentives for PBF project beneficiaries are paid on time	260 269 000	23 564 521	236 704 479	9.05%
PBF extension strategy is adopted by the MOH	25 500 000	745 400	24 754 600	2.92%
TOTAL SUB-COMPONENT A: Management and health systems at regional and district levels	**640 880 087**	**202 202 450**	**438 677 637**	**31.55%**

Annual action plan of the H2S Component		Cumulative spending for Year 2	Balance for fiscal year 2	% of annual budget executed
Line of action	**BUDGET CFA F**			
Sub-Component B: Social financing mechanisms				
An institutional framework for support to social insurance bodies adapted to the UEMOA regulation is set up (national authority on social insurance, guarantee fund)	500 000	2 317 000	(1 817 000)	463.40%
A strategy to regulate the organization of MHOs in consolidated risk pools at the departmental or district level is adopted	13 377 200	4 109 500	9 267 700	30.72%
Templates for MHO financial reports and technical reports are developed	8 000 000	9 133 660	(1 133 660)	114.17%
MHOs are operational in all local government units in the three (3) focus departments	38 000 000	97 603 486	(59 603 486)	256.85%
A risk-pooling mechanism is developed to share large risks and professionalize risk-management in each of the three (3) focus departments	6 000 000	113 900	5 886 100	1.90%
MHOs and MHO networks in the entire intervention zone of the Component are functional	20 250 000	28 319 005	(8 069 005)	139.85%
Partnerships between MHOs and micro-finance institutions in focus departments are established during the course of this year and subsequent years	4 000 000	-	4 000 000	0.00%
The PLWHA support project in Kaolack is extended to the region of Ziguinchor	12 000 000	1 851 592	10 148 408	15.43%
Health insurance, through MHOs, is effectively provided to vulnerable groups in at least thirty (30) MHOs	2 500 000	917 400	1 582 600	36.70%
TOTAL SUB-COMPONENT B: Social financing mechanisms	**104 627 200**	**144 365 543**	**(39 738 343)**	**137.98%**
Sub-Component C: National level health policies and systems				
Implementation of the community health policy is supported	2 000 000	783 844	1 216 156	39.19%

Annual action plan of the H2S Component		Cumulative spending for Year 2	Balance for fiscal year 2	% of annual budget executed
Line of action	**BUDGET CFA F**			
At least one (1) policy initiative in the maternal and newborn health, family planning, child health, malaria, HIV/AIDS and tuberculosis areas is supported	80 000 000	5 689 330	74 310 670	7.11%
Capacities of the PNA in procurement procedures are strengthened	-	-	-	
At least one (1) HSS policy initiative supported	60 000 000	48 701 586	11 298 414	81.17%
The necessary tools for the establishment of regional MTEFs for the health sector are validated	8 500 000	16 403 920	(7 903 920)	192.99%
AWP management software is finalized	8 500 000	57 194 925	(48 694 925)	672.88%
A budget arbitration and monitoring system is set up by DAGE/MOH	4 000 000	920 000	3 080 000	23.00%
The 2014-2016 MTEF for the health sector is prepared within the required time-limit	2 000 000	213 500	1 786 500	10.68%
The performance repot of the 2012 health sector MTEF is delivered within the required time-limit	14 250 000	4 480 500	9 769 500	31.44%
The annual financial report of DAGE is prepared within the required time-limit	3 000 000	1 357 600	1 642 400	45.25%
TOTAL SUB-COMPONENT C: National level health policies and systems	**182 250 000**	**135 745 205**	**46 504 795**	**74.48%**
Activity area D: Coordination				
PBF procedures manual adopted by all Health Program Components and other MOH partners	3 519 500	-	3 519 500	0.00%
Steering Committee meetings are held as scheduled	-	1 297 100	(1 297 100)	
At least two (2) inter-agency thematic group reports prepared and validated	11 947 200	10 962 934	984 266	91.76%
Action plan and budget for FY2013 are prepared	10 438 900	12 277 826	(1 838 926)	117.62%
Progress reports prepared within required time-limits (bi-weekly updates, quarterly reports and	12 648 300	5 836 384	6 811 916	46.14%

Annual action plan of the H2S Component		Cumulative spending for Year 2	Balance for fiscal year 2	% of annual budget executed
Line of action	**BUDGET CFA F**			
annual report)				
TOTAL ACTIVITY AREA D: COORDINATION	**38 553 900**	**30 374 244**	**8 179 656**	**78.78%**
Total Action Plan	**966 311 187**	**512 687 442**	**453 623 745**	**53.06%**

Attachment 2: Indicators of the H2S Component

Indicators	2011 Reference	Reminder of 2012 results (Year 1)	2013 Target	2013 results (Year 2)	Observations
Indicator 1: Proportion of health districts where the functions of DMO and those of the chief medical officer at the health center are separated	ND	19%	25%	31%	Only 16 out of 52 districts complied, but relating these 16 districts to the 37 that have more than one physician, the rate is 43%.
Indicator 2: Proportion of Service Delivery Points (SDP) that have displayed the cost of medicines and services	73%	55%	95%	64%	The situation has improved but target has not been met.
Indicator 3: Proportion of health districts with a technical execution rate of AWPs ≥ 80%	ND	22%	100%	ND	Data for 41 out of 52 districts is available for 2012 resulting in improved monitoring as information was not available for 2011. Only 9 districts meet this criterion. 2013 data will be available in 2014.
Indicator 4: Number of medical regions that have organized a high quality JPR	100% in 2011	100%	100%	100%	It shall however be noted that the regions of Ziguinchor and Diourbel held their JPRs after the national JPR.
Indicator 5: Number of audit reports delivered on time	NA	0%	100%	0%	The first joint verification mission was significantly delayed due to the selection process of the audit firm and this delay is yet to be addressed. However, six reports have been produced by the audit firm for the three quarters of 2012, i.e. one report par quarter and per region. For Year 2, CRGs conducted their first verification mission in 2013 covering the first half of the year for the districts of Kolda

Indicators	2011 Reference	Reminder of 2012 results (Year 1)	2013 Target	2013 results (Year 2)	Observations
					and Kaffrine. Each CRG submitted a report to the other CRG**.**
Indicator 6: Proportion of reimbursement requests paid on time	NA	0%	100%	0%	Delays in the verification process have a ripple effect on the payment process. However, 15 signatories have effectively received bonuses for the 3 quarters, i.e. 45 payments made for Year 1 of PBF. For Year 2, no payments have yet been made.
Indicator 7: Number of health districts involved in performance-based financing	NA	3	7	7	The district of Darou Mousty did not finally implement PBF and the five new districts signed their contracts between July and August 2013.
Indicator 8: Number of MHOs that received public subsidies following the establishment of mechanisms by the government	NA	NA	50	ND	The government granted 50 million CFA francs to each of the 11 existing regional federations (all regions except Matam, Tambacounda and Kédougou as they do not have MHO federations yet).
Indicator 9: Number of beneficiaries covered by community-based MHOs	182842	263 343	330 000	337 872	The target has been reached. However, only 117,661 beneficiaries (34.8%) were up-to-date with their premium payments at the end of August.
Indicator 10: Number of vulnerable persons covered through MHOs with the support of a third-party payer	21 862	22 438	33 000	31 876	Vulnerable groups make up 9.4% of beneficiaries.
Indicator 11: Number of policy papers approved and regulatory acts adopted for the implementation of policy initiatives developed by the EIPS	2	13	≥ 1	2	The community health policy paper and the UHC strategic plan were developed with the support of the Component.

Indicators	2011 Reference	Reminder of 2012 results (Year 1)	2013 Target	2013 results (Year 2)	Observations
Indicator 12: Health sector budget as a percentage of the national budget	13.6%	10.2%	15%	10.7%	Data for this indicator is provided by the MEF.
Indicator 13: Deadline for production of the performance report of the health sector MTEF for year n-1 is met (May)	No	Yes	Yes	Yes	Presentation at the JPR in June MTEFs shall be replaced by the Multi-Year Expenditure Programming Document (DPPD) as of 2014.
Indicator 14: Amount allocated (in CFA francs) to districts and medical regions by Program components through the direct financing mechanism	NA	NA	ND	519 400 000 F CFA	An amount of 99,390,118 CFA francs was mobilized for the payment of the first milestone: 46,639,196 CFA F for Thiès, 29,200,000 CFA F for Kaolack and 23,550,922 CFA F for Kolda.
Indicator 15: Amount allocated (in CFA francs) to districts, medical regions and EPS by Program components through the PBF mechanism for the payment of bonuses	NA	0	260 269 000 CFA F	23 564 521 CFA F	The series of three PBF bonus payments already made relate to performance contracts signed by 15 beneficiaries in 2012. These payments were made in January 2013, April 2013 and July 2013.
Indicator 16: Proportion of progress reports of the Component prepared within the required time-limit	100%	100%	100%	100%	Four quarterly reports and an annual report were submitted on time. Bi-weekly updates were prepared on a regular basis (18 in 12 months).